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FAGAN
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Submitter : Dr. Daniel Raess **Date:** 06/24/2005

Organization : St Fransic Hospital and health Care Centers

Category : Physician

DRG/GEN

Issue Areas/Comments

GENERAL

GENERAL

I am writing to support increasing DRG 525 to keep pace with new developements in VAD technology. Currently, we are using external LVAD such as the Abiomed AB 5000 to support patients in cardiogenic shock after acute MI. These patients need a much longer period of support(as much as 30 days)and we are therefor expending much more on these cases than we are being reimbursed. Interestingly, these patients are better served by this form of therapy, therby avoiding transplantation and going home with thier own hearts that have recovered.

Present reimbursement has not kept up with the change in technology. DRG 525 should be increased to reflect those changes. Alternate therapy such as transplantation is by far a more costly alternative that profoundly affects the longevity and quality of life in this group of patients.

Thankyou for your attention to this issue.

CMS-1500-P-742

Submitter : Mr. Roger Sarao

Organization : New Jersey Hospital Association

Category : Hospital

Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

See attachment for detailed comments.

Dear Dr. McClellan:

On behalf of the New Jersey Hospital Association (NJHA), its 112 member hospitals, health care systems and other health care organizations, we appreciate the opportunity to submit comments on the fiscal year (FY) 2006 inpatient prospective payment system (PPS) proposed rule. While the NJHA is supportive of many of the provisions in the proposed rule, we are particularly concerned about the potential underestimation of the market basket and the proposed expansion of the post-acute care transfer policy.

Current law sets the FY 2006 inpatient PPS update for hospitals at the rate of increase in the market basket, now estimated at 3.2 percent. Legislative and proposed regulatory changes, however, along with technical adjustments to ensure budget neutrality would result in a proposed average per case payment increase of only 2.5 percent. At the same time, the current estimate of the actual market basket increase for FY 2005 is 4.1 percent. We are concerned that CMS is dramatically underestimating the market basket for FY 2006. We request that CMS review and revise the methodology used to determine the projected FY 2006 market basket.

In 2003, 54 percent of the nation?s hospitals had negative Medicare inpatient margins and one out of every three hospitals was losing money overall. In the state of New Jersey, nearly 40 percent of hospitals closed the year with a negative operating margin. Hospitals cannot continue to receive actual updates that are less than the rate of hospital inflation. We will continue to urge Congress to provide adequate Medicare reimbursement to hospitals. And in our comments on this proposed rule, we also encourage CMS to make changes that would prevent further decline in Medicare payments.

We are very disappointed that the rule contains a proposal to further expand the post-acute care transfer policy, which would reduce hospital payments nationally by nearly $900 million in FY 2006 alone. New Jersey hospitals would experience payment reductions totaling $26 million. This policy is not in the best interest of patients or caregivers. It undermines clinical decision-making and penalizes hospitals for providing the right care at the right time and in the right setting. This policy must be withdrawn.

Attached are NJHA?s detailed comments regarding CMS?s proposed changes to the inpatient payment system. The NJHA appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please feel free to contact me at 609-275-4022.

Sincerely,

Sean Hopkins
Senior Vice President

CMS-1500-P-742-Attach-1.DOC

Attachment to #742

NJHA
NEW JERSEY HOSPITAL ASSOCIATION

June 24, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1500-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1500-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule.

Dear Dr. McClellan:

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HOSPITAL MARKET BASKET

The hospital update is based on a market basket factor that is intended to reflect the average change in the price of goods and services hospitals purchase to furnish inpatient care. These price changes must be projected forward to estimate increases for the subsequent year so that an appropriate inflationary update can be determined in advance of payment. The payment system is prospective, and the update is not retroactively reconciled to reflect actual price increases for the year. Therefore, a reliable projection methodology is vital to ensure equitable payments.

According to the American Hospital Association (AHA), for 7 of the last 8 years, the market basket projection has been lower than the actual increase. While the market basket was over-estimated for a number of years prior to that time, a methodology change was made in 1998 that appears to have over-corrected for the previous underestimations. For example, the actual increase in FY 2003 was 3.9 percent while the projected increase was 3.5 percent. In FY 2004 the actual was 3.8 percent compared to a 3.4 percent projection. CMS reports that, based on the most recent data, the FY 2005 market basket increase is now estimated to be 4.1 percent compared to the projected 3.3 percent increase that was used to determine the update factor. We are concerned that the methods used to project the market basket increase are flawed and fail to provide a reliable estimate of hospital cost increases. Given a 4.1 percent cost increase for FY 2005, a projected FY 2006 increase of 3.2 percent does not seem reasonable. **We request that CMS review the methodology that was used to determine the projected FY 2005 market basket and revise it for the FY 2006 projection. We also urge CMS to make the details of the calculation available to the public.**

HOSPITAL QUALITY DATA

To determine if a hospital qualifies for its full Medicare market basket update in FY 2006, CMS must determine if a hospital has submitted data on the 10 measures of heart attack, heart failure, and pneumonia care that were the starter set for the Hospital Quality Alliance. The proposed rule for FY 2006 states several requirements for data to be considered submitted for purposes of receiving the full market basket update. These requirements include the hospital's continuous submission of quarterly data on the 10 measures; the submission of the data for patients discharged through the 4th quarter of 2004 by May 15, 2005; and the validation of the hospital's 3rd quarter 2004 data.

To pass validation, the hospital must send copies of the relevant medical record information from five patient records chosen at random from among those on whom the hospital has submitted data. CMS has contracted with an organization that will re-abstract all of the required data from the five records. If there is at least an 80 percent agreement between the information that the contractor has abstracted and the information the hospital abstracted for all of the measures that are applicable to those patients, then the hospital will have passed validation. If not, then the contractor will compare only those data elements that are required for the 10 required measures. If there is at least an 80 percent agreement on those required elements, then the hospital will have passed validation. If the hospital has not passed validation, it can appeal the results of the contractor's work to the contractor. The state's Quality Improvement Organization will review and recommend to the contractor a disposition of the appeal. The contractor will reassess the hospital's submission in light of this additional information. Finally, if the hospital is unsuccessful in its appeal, it can ask that its 4th quarter data be used as well to determine

validation. The hospital will have to submit the five randomly selected charts from its 4th quarter discharges by August 1, which is ahead of the normal schedule, and the contractor will use both the 3rd and 4th quarter charts to determine if the data validate at least 80 percent of the time.

The NJHA strongly supports the need for validation of the data that are submitted for the HQA. Validation is helpful in assuring that all information is being collected and processed similarly so that the publicly reported data create a reliable picture of the quality of care provided in each participating hospital. However, the law only calls for the submission of the data for hospitals to qualify to receive the full payment update. We believe that Congress recognized that taking submitted data and turning it into information that could be publicly reported is a process, and that there could be imperfections in that process. In linking payment to the submission of data, Congress suggested that hospital payments should not be held hostage to CMS or its contractors being able to correctly carry out the processing of the hospital data.

To date, there is enough evidence of flaws in the validation process to suggest that passing validation should not be a criterion for receiving the full Medicare market basket update. The validation process is sufficiently flawed that when it identifies a problem, one can only conclude that there is a difference between the information the hospital submitted and the data the contractor abstracted. No assumption can be made about which organization has correctly abstracted the data from the medical records. There have been numerous problems including logistical issues such as failure to get the request for the five files into the hands of a responsible authority at the hospital. In addition, data collection issues have arisen such as the misalignment of the data abstraction instructions hospitals were allowed to use and the instructions that the contractor had to adhere to in re-abstracting the data. Furthermore, processing issues have occurred such as the fact that hospitals have submitted appeals indicating why their data submissions were correct and the contractor's re-abstractions were incorrect, have had their quality improvement organizations verify to the contractor that the hospital has correctly submitted the data, and had their appeals turned down without explanation. The AHA has begun to collect information about the problems with the validation process that have been identified by hospitals so that they can work with CMS to correct the validation process to ensure its accuracy and reliability. The NJHA supports AHA's efforts to improve the validation process.

However, until the validation process is reliable, NJHA opposes the proposed link between meeting the validation requirements and receiving the full market basket update. The CMS's validation process is not currently reliable and needs improvement before it is used in determining which hospitals receive full updates.

LABOR-RELATED SHARE

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to update the inpatient PPS market basket at least once every five years. CMS proposes to update it every four years, beginning with rebasing and revising the market basket for FY 2006. For FY 2003, CMS rebased the market basket using 1997 data; however, CMS continued to calculate the labor-related share based on the 1992 data. The 1997 data would have raised the labor-related share to 72.5 percent from 71.1 percent, but there was concern at the time that the increase would hurt rural facilities that primarily have area wage indexes (AWIs) below 1.0.

CMS cited the need to conduct additional analyses in deciding to leave the labor related share at the 1992-based 71.1 percent. Shortly after, Congress included in the MMA a provision that held hospitals with a wage index below 1.0 at a 62 percent labor-related share.

For FY 2006, CMS is proposing to reduce the labor-related share from 71.1 percent to 69.7 percent, which is due to the use of more recent data and the removal of postage from the labor-related share. This proposed change, if adopted, would adversely affect hospitals with an AWI greater than 1.0. The labor share for hospitals with AWIs less than 1.0 will remain at 62 percent as specified in the MMA. This change would be applied in a budget neutral manner by increasing the standardized amount for all hospitals.

We are concerned about CMS making any changes to the calculation of the labor-related share devoid of a broader plan to refine the methodology. Given that CMS was unable to discover an alternative methodology that is accurate, reliable, and reasonably easy to apply, the NJHA believes CMS should leave the labor-related share at 71.1 percent.

In particular, we are concerned about the removal of postage from the labor-related categories. CMS's assertion in 2003 that additional analyses are needed still stands today. The NJHA believes that CMS should continue to consider this category labor-related until a broader look at the calculation of the labor-related share is taken. Arbitrarily pulling out one item, postage, will unfairly penalize those hospitals in high wage areas.

We are also concerned about the large drop in the other labor-intensive services category (landscaping, protective services, laundry, etc.). We would urge CMS to investigate this drop and whether it is a result of a flaw in the methodology. For instance, an inappropriately low growth factor could cause an improper category weight and the underestimation of the market basket.

This provision will have a detrimental affect on high-wage area hospitals while diverting funds back to low-wage hospitals that have already been protected through the MMA. **The NJHA urges CMS to leave the labor-related share at 71.1 percent for FY 2006 and recommends that CMS continue investigating alternative methodologies for computing the labor-related share.**

POST-ACUTE CARE TRANSFERS

Medicare patients in certain DRGs who are discharged to a post-acute care setting – such as rehabilitation hospitals and units, long-term care hospitals, or skilled nursing facilities – or are discharged within three days to home health services are considered a transfer case if their acute care length of stay is at least one day less than the national average. These cases are paid a per diem rate, rather than a fixed DRG amount, up to the full inpatient PPS rate.

The NJHA is very disappointed with CMS's continued effort to expand the post-acute care transfer policy. In the proposed rule, CMS discusses the possibility of expanding the policy from 30 DRGs to either 223 DRGs (later revised to 231) or all DRGs. Specifically, CMS proposes to expand the application of the post-acute care transfer policy to any DRG that meets the following criteria:

- At least 2,000 discharges to post-acute care;
- At least 20 percent of its discharges are to post-acute care;
- At least 10 percent of its discharges to post-acute care occur before the geometric mean length of stay for the DRG;
- A geometric mean length of stay of at least three days; and
- If the DRG is one of a paired set of DRGs based on the presence or absence of a comorbidity or complication, both paired DRGs are included if either one meets the first three criteria above.

The NJHA is frustrated with CMS's continued attempts to find the right criteria to achieve the desired budget results, rather than the right policy regardless of its budget implications. The AHA conducted analyses to better understand the impact of the proposals in the rule as well as the revised list of DRGs potentially subject to the policy. This misguided approach to expand the policy to 231 DRGs will have a devastating impact on hospitals by reducing overall payments by an estimated $894 million nationally when the effects on disproportionate share hospital (DSH), indirect medical education (IME), capital and outliers payments are considered. This is particularly problematic given that more than 50 percent of hospitals nationally are already losing money treating Medicare inpatients and overall Medicare margins have been dropping every year since 1997 to an estimated *negative* 1.9 percent. **The NJHA modeled the impact to New Jersey hospitals of expanding the transfer provision to 231 DRGs and determined that, statewide, providers would experience a reduction in Medicare reimbursement of $26 million in FY 2006 alone.**

The expansion of the transfer policy undercuts the basic principles and objectives of the Medicare prospective payment system. The Medicare inpatient PPS is based on a system of averages. Cases with higher than average lengths of stay tend to be paid less than costs while cases with shorter than average stays tend to be paid more than costs. The expansion of this policy makes it impossible for hospitals to break even on patients that receive post-acute care after discharge. Hospitals "lose" if a patient is discharged prior to the mean length of stay, and they "lose" if patients are discharged after the mean length of stay.

In the July 31, 1998 publication of the FY 1999 final rule implementing the policy for the original 10 DRGs, CMS included an analysis showing that across almost all lengths of stay for each of the 10 DRGs, hospitals would, on average, be paid in excess of their costs even after the implementation of the provision. We have not seen any such data for the new proposed 231 DRGs, and we believe expansion of the provision is just a back door budget cut to hospitals – especially given that Health Economics Research, Inc. in its report of July 31, 2000, showed that short-stay post-acute transfer cases are 7.4 percent more costly than short-stay non-post acute care transfer cases. **While the length of stay may be shorter, the level of services provided during the stay is more intense and costly.**

The post-acute transfer policy penalizes hospitals for efficient treatment, and for ensuring that patients receive the right care at the right time in the right place. The policy disadvantages hospitals that make sound clinical judgments about the best setting of care for

patients – and this setting is often outside of the hospital's four walls. Hospitals should not be penalized for greater than average efficiency. Particularly, facilities in regions of the country where managed care has yielded lower lengths of hospital stay for *all* patients are disproportionately penalized.

The post-acute transfer policy is not necessary, as the perceived "gaming" hypothesis does not exist. When Congress first called for expansion of the transfer policy in the Balanced Budget Act of 1997 (BBA), data showed that Medicare inpatient lengths of stay were dropping, and that both use and cost of post-acute care by Medicare beneficiaries was growing. Since that time, however, inpatient length of stay has stabilized. Medicare spending on post-acute care has slowed as post-acute payment systems have moved from cost-based reimbursement to prospective payment. Additionally, studies by the AHA and others show that the majority of patients who use post-acute care have longer – not shorter – hospital stays than patients that don't use post-acute care, demonstrating that these patients are truly "sicker" and in need of additional care. In FY 2004, for instance, patients that were not transferred to post-acute care had an average length of stay of 4.93 days, while those who did receive post-acute care had an average length or stay of 7.51 days. If the agency is concerned about premature discharges, then we recommend it focus on improving the quality review process rather than further expand the transfer provision.

Section 1886(d)(4)(J) of the Social Security Act directs CMS to focus on those DRGs that have a high volume of discharges to post-acute care and a disproportionate use of post-discharge services. It is inherently impossible for all DRGs, or even 231, to have *disproportionate* use of post-discharge services. The 231 DRGs selected by CMS represent 88 percent of all DRGs with patients discharged to a post-acute care in FY 2004. Clearly, 88 percent of DRGs with *any* post-acute care use cannot have *disproportionate* use. Furthermore, CMS is also capturing DRGs that are not at all *high-volume*. For example, DRG 473 (acute leukemia without major operating room procedure age > 17) has 2,070 discharges to post-acute care as compared to DRG 544's (major joint replacement or reattachment of lower extremity) 349,085 discharges to post-acute care. It cannot be argued that while DRG 473 does not have a *high-volume* of discharges to post-acute care, it still has *disproportionate* use. Only 22.7 percent of the cases in DRG 473 were discharged to post-acute care versus 83 percent for DRG 544. **CMS's current criteria cast far too wide of a net and capture far more DRGs than appropriate.**

Furthermore, it is unclear whether this policy will end up costing the Medicare program as a whole more money. Patients that are kept in the inpatient setting longer may not be discharged to skilled-nursing care or rehabilitation care, but may receive home health and additional physician services in both the inpatient and outpatient settings that increase the costs of care. **We encourage CMS to take a broader look at the total cost of care across a full patient episode, rather than focusing on the distinct portions of the care captured under individual payment systems.**

The NJHA objects to an expansion of the post-acute care transfer policy, which is not in the best interests of patients or caregivers. It undercuts the basic principles and objectives of the Medicare PPS, undermines clinical decision-making and penalizes hospitals for

providing efficient care, at the most appropriate time and in the most appropriate setting. This provision must be withdrawn in its final rule.

OPERATING PAYMENT RATES

Outlier Payments

The rule proposes to establish a fixed-loss cost outlier threshold equal to the inpatient PPS rate for the DRG, including IME, DSH and new technology payments, plus $26,675. While this is not a particularly sizable increase from the FY 2005 payment threshold of $25,800, we are concerned that the threshold is too high. CMS states in the proposed rule that actual outlier payments for 2005 are estimated to be 0.7 percentage points lower than the 5.1 percent of funds withheld from hospitals to fund outlier payments and that the payments in 2004 were 1.6 percentage points lower than the funds withheld.

In the rule, CMS proposes to use a one-year average annual rate-of-change in charges per case from the last quarter of 2003 in combination with the first quarter of 2004, to the last quarter of 2004 in combination with the first quarter of 2005, to establish an average rate of increase. This results in an 8.65 percent rate of change over one year or 18.04 percent over two years.

The NJHA appreciates that CMS is proposing this methodology in an effort to avoid using data prior to the major changes in the outlier policy. **However, using the proposed charge inflation methodology will only result in an inappropriately high threshold and a real payment cut to hospitals. The NJHA strongly opposes using this methodology to estimate the outlier threshold, and instead endorses the following methodology as proposed by the AHA in its comment to CMS:**

> "The AHA conducted a series of analyses to identify a more appropriate methodology. Below we put forth for CMS's consideration a methodology that incorporates both cost inflation and charge inflation. The use of more than one indicator may make the threshold calculation more accurate and reliable.
>
> First, we inflated 2004 charges by 18.04 percent (the inflation factor used by CMS in the proposed rule) and then reduced the charges to costs. Instead of using the cost-to-charge ratios (CCRs) from the CMS Impact File, we used the CCRs from the March 31, 2005 HCRIS release. In addition, we accounted for the 9-month lag from the end of a cost reporting period until the fiscal intermediary is able to update the CCR. We accomplished this by projecting forward from the most recent fiscal period in the March 31, 2005 HCRIS update to the fiscal period(s) expected to be used for the calculation of the CCR(s) determining federal FY 2006 outlier payments.
>
> The cost inflation factor for projecting CCRs was determined from the cost reports of a cohort of 3,756 matched hospitals for periods beginning in federal FYs 2001, 2002 and 2003. All three costs reports were available for each hospital from the recent update of HCRIS. The 2001-2003 aggregate annual rate of

increase in the cost per discharge for these hospitals was 6.57 percent[1]. This cost inflation factor and the CMS charge inflation factor of 8.65 percent were used to project cost to charge ratios over the time periods described above. The projected CCRs were applied to projected FFY 2006 charges to simulate the determination of costs for FFY 2006 outlier payments. **The estimated fixed loss amount that would result in 5.1 percent outlier payments under this methodology is $24,050.**

The AHA strongly urges CMS to adopt this methodology. We estimate that the fixed-loss threshold to achieve 5.1 percent in FY 2005 should have been set at $21,640 as compared to the $25,800 actually utilized. CMS under spent the funds set aside for outliers by an estimated $610 million in FY 05 and $1.3 billion in FY 04. **If CMS leaves the threshold at $26,675, rather than dropping it to $24,050, we believe that CMS will under spend by at least $510 million."**

The NJHA strongly endorses the alternate methodology proposed by the AHA as outlined above in calculating the fixed-loss threshold for Medicare outlier payments, and urges CMS to adopt this methodology for FY 2006.

OCCUPATIONAL MIX ADJUSTMENT

FY 2006 Adjustment

The occupational mix adjustment to the wage index is intended to control for the effect of hospitals' employment choices – such as the use of registered nurses versus licensed practical nurses or the employment of physicians – rather than geographic differences in the costs of labor. CMS proposes no changes to the methodology used in FY 2005 in the proposed rule, and indicates that nearly one-third of rural areas and over one-half of urban areas would see a decrease in their wage index as a result of this adjustment. Given the potential financial impact of a full adjustment on hospitals, concerns regarding the data, and changes in the regulatory environment such as state-mandated minimum nurse staffing ratios, CMS is proposing to again limit the application of the occupational mix adjustment to 10 percent of the wage index. **Due to the concerns CMS expresses in the proposed rule, the NJHA is supportive of this moderated implementation of the occupational mix adjustment.**

Future Data Collection

In addition, the NJHA urges CMS to release a proposed survey for comment as soon as possible. The sooner the survey is out in the field, the more likely the data will be accurate and reliable. We urge CMS to allow for an appropriate amount of time to develop the survey, provide clear instructions, adapt the systems, collect the data, prepare the survey responses, audit the data, correct the data, and calculate the adjustment. Given that CMS must have the adjustment ready for the FY 2008 adjustment (or the April 2007 proposed rule), **the NJHA recommends that**

[1] An audit adjustment was applied to costs from "as submitted" cost reports. The audit adjustment was determined by comparing 1,881 "as submitted" cost reports from the December 31, 2003 HCRIS database with the settled reports of the same hospitals in the March 31, 2005 HCRIS update.

CMS release the proposed survey this summer to meet this timeframe and allow hospitals adequate time to prepare for the data collection and reporting.

WAGE INDEX

Wage Index Calculation Change

The inpatient PPS proposed rule for 2006 contained a change in the wage index calculation. This change was made in step 4 of the Computation of the Proposed FY 2006 Unadjusted Wage Index on page 23373 in the *Federal Register*.

The change is in the calculation for Overhead Wage-Related Cost Allocation to Excluded Areas. This calculation is made up of three steps:

1. Determine the ratio of overhead hours to revised hours.
2. Compute overhead wage-related cost by multiplying the overhead hour's ratio from step 1 by wage-related costs.
3. Multiply the overhead wage-related costs by the excluded hour's ratio.

The change in the calculation occurred in step 1. For 2006, the calculation for revised hours was changed to subtract excluded areas (Lines 8 and 8.01). This change results in a higher ratio for step 1, which results in an increase in the overhead cost allocated to excluded areas. This change ultimately lowers the hospital's average hourly rate.

The NJHA is concerned that CMS would make such a change to the calculation of the wage index without any discussion. We request that CMS explain the basis for the change and how a proper allocation can be achieved using the formula set forth in the proposed rule. Providers should be given an opportunity to comment on this revision to the methodology before it is implemented. The NJHA believes that this methodological revision will have a significant impact on the wage indexes for some hospitals. **Accordingly, we believe that CMS should return to the established methodology and go through the full notice and comment process before making such a change. We further recommend that hospitals be given an opportunity to withdraw or reinstate their requests for geographic reclassification within 30 days of the publication of the Final Rule.**

Out-Migration Adjustment

Hospitals that qualify for an out-migration adjustment and do not waive the application of the adjustment are not simultaneously entitled to reclassification pursuant to Sections 1886 (d)(8) or (d)(10). Because of significant changes to the wage index that took place in FY 2005, CMS allowed hospitals to withdraw or reinstate their geographic reclassification applications within 30 days of the publication of the FY 2005 Final Rule. By doing so, CMS acknowledged that changes made between the proposed and final rules could affect whether a hospital was better off accepting the out-migration adjustment or whether it would be more advantageous for a hospital to waive the out-migration adjustment and pursue geographic reclassification.

Although the changes to the wage index are not as extensive for FY 2006, the NJHA believes there is still a likelihood that revisions made between the proposed and final rules may impact a hospital's choice of whether to accept the out-migration adjustment or whether to apply for

geographic reclassification. **Thus, the NJHA requests that CMS implement a policy similar to last year's and allow hospitals to withdraw or reinstate their geographic reclassification applications within 30 days of the date that the Final Rule is published.**

For FY 2006, the second year of the out-migration adjustment, CMS is applying adjustments that are identical in amount to the adjustments given to qualifying hospitals in FY 2005. It appears that hospitals will receive the same adjustment in each of the three years of eligibility for the out-migration adjustment. The NJHA does not believe that the governing statute, Section 505 of the MMA, requires that the adjustments be identical for all three years. The statute only requires that the adjustment be granted for a three-year period.

The NJHA believes that it is not logical or fair to freeze the amount of the adjustment for three years. Because of changes in the wage index each year, some hospitals will be receiving out-migration adjustments even though the wage index for their geographic area is now higher than the wage index for the county to which their residents are commuting. Likewise, there may be hospitals that would be entitled to a higher out-migration adjustment if it were recalculated based on the new wage indexes for FY 2006. The three-year eligibility period for the out-migration adjustment is similar to the three-year eligibility period for geographic reclassifications, but the wage indexes for the latter change each year despite the guaranteed three-year reclassification. **The NJHA recommends that CMS revise its policy so that the out-migration adjustment will be recalculated each year based on updated wage data and the new wage indexes.**

Urban Group Reclassifications

The NJHA is pleased that CMS is proposing to allow counties that are included in a Combined Statistical Area (CSA) to reclassify to a contiguous metropolitan division of the CSA using the 2000 standards. We believe that this is an appropriate policy approach and acknowledges the realities of areas that are just outside major metropolitan areas and must meet the competitive salary scales in order to attract and retain competent professionals to provide needed hospital services in areas just outside these major metropolitan areas throughout the United States.

In addition, the NJHA is concerned that group reclassifications will be affected by the timing of section 508 of the MMA. We do not believe that Congress intended for the section 508 hospitals to prevent group reclassifications. In addition, section 508 is not budget neutral, thus it would be inappropriate to encourage such hospitals to forgo the section 508 funding to join a group reclassification at the expense of all other hospitals. **The NJHA urges CMS to allow section 508 hospitals to commit to a group reclassification and join after the section 508 funding expires.**

HOSPITAL REDESIGNAITONS AND RECLASSIFICATIONS

Hold-Harmless for Certain Urban Hospitals Redesignated as Rural

Last year, CMS discovered an instance where the approved redesignation of an urban hospital as rural resulted in the hospital's data adversely affecting the rural wage index. To address this concern, CMS proposes for FY 2006 to apply its hold-harmless rule that currently applies when rural hospitals are reclassified as urban to situations where urban hospitals are reclassified as rural. Thus, wage data of an urban hospital reclassifying into a rural area would be included in

procedure code categories 00 and 17 were created to capture a diverse group of procedures and interventions affecting all body systems. The establishment of these code categories was a deviation from the normal structure of ICD-9-CM and a stopgap measure to accommodate new technology when no other slots in the corresponding body system chapters (e.g., musculosketal system, circulatory system, etc.) were available. The plan was to use up codes in chapter 00 first and then start populating chapter 17.

We have now reached the point where category 00 is full and the C&M committee is entertaining proposals for codes in category 17. At the April 2005 C&M meeting a proposal was presented that would in effect leave only 80 codes available in this category. Many of the specific body system chapters are already filled (like cardiac and orthopedic procedures). In recent years, as many as fifty (50) new procedure codes have been created in a single year. This means that it is possible for ICD-9-CM to completely run out of space in 1-1/2 years. We concur with the NCVHS recommendation to issue a proposed rule for adoption of ICD-10. We also would support an implementation period of at least two years following issuance of a final rule. Without the publication of even a proposed rule, the prospect of not being able to recognize new major surgical procedures and entirely new medical technology is a certain grim reality.

The NJHA strongly recommends that the Secretary undertake the regulatory process to replace ICD-9-CM with ICD-10-CM and ICD-10-PCS expeditiously. HHS should take the necessary steps to avert this crisis and avoid the situation of not being able to create new diagnosis or procedure codes to reflect evolving medical practice and new technology. It is easier to plan for this migration than respond to a crisis that will likely result in unreasonable implementation timeframes. It is imperative that the rulemaking process start immediately.

DRG RECLASSIFICATIONS

In general, the NJHA supports CMS's proposed changes to the DRG system, as the revisions appear rational given the data and information provided. However, we do have concerns about some of the proposals as detailed below.

MDC 1 (Diseases and Disorders of the Nervous System)

Strokes: CMS reviewed the possibility of creating a new DRG with a recommended title "Ischemic Stroke Treatment with a Reperfusion Agent." The data reviewed by CMS suggested that the average standardized charges for cases treated with a reperfusion agent are more than $16,000, or $10,000 higher than all other cases in DRGs 14 and 15 respectively. Although the data suggested that these patients are more expensive than all other stroke patients, CMS proposed not to make a change to the stroke DRGs because the conclusion was based on a small number of cases. CMS believed that the administration of tissue plasminogen activator (tPA) identified by ICD-9-CM procedure code 99.10 may be underreported because it currently does not affect DRG assignment.

The NJHA requests that CMS create a new DRG to recognize the additional resources associated with strokes and tPA administration even if the data analyzed did not have a large number of cases.

While it may be true that code 99.10 is underreported because it currently does not affect DRG assignment, the number of patients meeting the clinical indications for receiving tPA administration is low. Published clinical data show that only 2 percent of patients with stroke receive intravenous tPA nationally (*Archives Neurology*, 2004, March; 61) and the rate among community hospitals may be slightly less at 1.6 percent (*Stroke*, 2001 August; 32). These statistics are only slightly higher than the 1.16 percent rate found in CMS data for patients in DRG 14 without intracranial hemorrhage with code 99.10.

The effective administration of tPA requires that treatment be administered within 3 hours of onset of stroke, and only after ruling out hemorrhagic stroke by computed tomography. Intravenous (IV) thrombolytic agents are not recommended when the time of stroke onset cannot be ascertained reliably, including strokes recognized on awakening. These indications significantly limit the number of patients eligible for tPA administration.

According to published clinical studies, using IV tPA in clinical practice has proved very difficult. The biggest challenge is the ability to determine that symptom onset occurred less than 3 hours prior to the time of the tPA infusion. Patients need to be educated to recognize the symptoms of a stroke and to seek early treatment. Administration of tPA in stroke patients requires that the patient recognize that something is wrong, is transported to a hospital equipped to provide this therapy, undergoes a history and physical examination and CT scan, and has this scan read by a qualified radiologist—all within the 3 hours of initial onset of symptoms.

For all the clinical reasons noted above, it is unlikely that the number of stroke cases reported with code 99.10 will increase significantly in the near future. **Regardless, the additional resources required to treat these patients should be recognized with a new DRG.**

CC List

CMS has indicated that they are planning a comprehensive and systematic review of the complication/comorbidity (CC) list for the inpatient PPS rule for FY 2007. CMS considers this review to be consistent with the Medicare Payment Advisory Commission's (MedPAC's) recommendation that CMS improve the DRG system to better recognize severity.

We applaud CMS's efforts to keep refining the DRG system to better recognize severity of illness, and the resources required to treat those illnesses. However, we believe that this is a temporary fix and a more refined DRG system can only be accomplished with more specific clinical classification systems, capable of painting a more complete picture of a patient's condition and the services provided to treat those conditions - namely ICD-10-CM and ICD-10-PCS. We strongly agree with CMS's assessment in the May 9, 2002, hospital inpatient PPS notice of proposed rulemaking, that ICD-10 is an improvement over ICD-9-CM and that it will provide greater specificity and detail. Thus, we again urge CMS to implement ICD-10.

Furthermore, we are concerned that CMS may not be evaluating all diagnoses and procedures that could possibly affect a patient's severity of illness and/or the resources utilized. The current DRG grouper only considers 9 diagnoses and up to 6 procedures. Hospitals submit claims to CMS in an electronic format. The HIPAA compliant electronic transaction 837i standard allows up to 25 diagnoses and 25 procedures. Many fiscal intermediaries are ignoring or omitting the

these critical services in underserved areas is option two, which would exempt off-campus NICUs from only the distance limitation where all other provisions of the provider-based requirements under Sec. 413.65 are satisfied.

GRADUATE MEDICAL EDUCATION

Initial Residency Period

Last year, CMS instituted a new policy for weighting the direct GME resident count for residents that pursue specialties requiring an initial year of broad-based training, such as anesthesiology. The new policy allows the initial residency period to be based on the period of board eligibility for the specialty, rather than the clinical-base year. CMS now further proposes to base the initial residency period on the period of board eligibility for the specialty when a resident matches directly to an "advanced program" without regard to fact that the resident did not match for an initial clinical base-year training program. This would allow hospitals to be paid an entire full-time equivalent (FTE), rather than half of an FTE for such residents until they are board eligible. **The NJHA supports this change.**

Affiliation Agreements

Previously, rural hospitals that began residency-training programs on or after January 1, 2005 were able to establish affiliation agreements with hospitals that had existing residency programs. CMS now proposes to allow urban hospitals that create a new residency program to establish an affiliation agreement with another hospital so long as the agreement results in a positive adjustment to the hospital's resident FTE cap. This would prevent hospitals from creating new residency programs and then moving most or all of its residents over to an existing program. **The NJHA supports the expansion of the hospitals that may enter into affiliation agreements.**

IME ADJUSTMENT

No IME FTE count was calculated for those hospitals that were exempt from the inpatient PPS for cost-reporting periods ending on or before December 31, 1996. Thus, for inpatient PPS exempt hospitals that wish to covert to the inpatient PPS, CMS proposes to established the IME FTE count on the GME FTE count based on the cost reports ending on or before December 31, 1996. **The NJHA supports the use of the GME FTE count based on the cost reports ending on or before December 31, 1996 and further suggests that CMS clarify that the policy would apply to both freestanding hospitals and hospital-based distinct part units that convert to the inpatient PPS.**

SPECIALTY HOSPITALS

In the inpatient PPS notice, CMS reported that it had come to their attention that some specialty hospitals might not meet the Medicare statutory definition of a hospital and therefore were not eligible for Medicare certification as a hospital or for the protection of the "whole hospital" exception under the federal physician self-referral law. This conclusion appears to be drawn from their review of applications for grandfathering under Sec. 507 of the MMA that imposed an 18-month moratorium on physician self-referrals to certain new specialty hospitals. It undoubtedly was also drawn from the fact that both the MedPAC and the CMS congressionally-mandated studies of specialty hospitals had been unable to include surgical and orthopedic

hospitals in many of their analyses because they had so few inpatient admissions. It appeared that many specialty hospitals – especially surgical and orthopedic hospitals – were focused primarily on outpatient surgery.

Subsequently, in testimony before Congress, CMS announced its plan to revisit the procedures by which applicant hospitals are examined to ensure compliance with relevant federal standards, as well as an examination of how specialty hospitals should be treated under EMTALA (the Emergency Medical Treatment and Labor Act). Further, CMS indicated that its fiscal intermediaries had been instructed to refrain from processing further Medicare participation applications from specialty hospitals until a comprehensive review of its enrollment process was completed. This process is expected to take at least six months. On June 9, the day after the Congressional moratorium had expired, CMS issued a fact sheet outlining next steps. The fact sheet provided additional details on CMS's plans to solicit input on these issues. It also indicated that the instructions to fiscal intermediaries also included suspension of authorization for initial surveys of state survey agencies during the review period. Finally, it indicated that the suspension would not apply to specialty hospitals that had submitted an enrollment application or requested an advisory opinion regarding grandfathering under the moratorium prior to June 9, 2005.

The **NJHA commends CMS for recognizing this problem, for undertaking this review, and for suspending enrollment applications in the interim**. We would like to take this opportunity to comment on the issues raised by this action, not only in the notice but also in CMS's subsequent notices. The issues we address below include:

- Application of the definition of a hospital.
- Treatment of specialty hospitals during the review process.

Application of the Definition of a Hospital. We appreciate the complexity of CMS's task in applying the statutory definition of a hospital, especially the requirement that the entity be primarily engaged in providing services to inpatients. While it has been amended across time, it is still a forty-year-old definition that is not necessarily reflective of current medical care and technology. Of necessity, we believe CMS will need to exercise some flexibility.

First and foremost, **NJHA recommends that CMS focus on what the public expects of any entity labeled a "hospital" whether they are full-service or limited-service hospitals.** All Medicare-certified hospitals should have to meet all relevant Medicare conditions of participation (COPs), but the **core requirement that we believe CMS should stress for specialty hospitals (some existing and some suggested new requirements) are:**

- **An adequately staffed inpatient capacity**, including a full-functioning quality monitoring and improvement system. The Medicare COPs already require this.

- **The ability to deal with complications that may arise during or after a surgical procedure in a way that protects the patient's well-being**. That means internal teams capable of handling those complications typical to the procedures normally performed in that hospital and, when transfers are needed to access other specialties or services at

another hospital, EMTALA-like provisions should apply with respect to how the transfer is executed and communication with the receiving hospital. Other comments related to the application of EMTALA to specialty hospitals will be addressed separately in comments to the EMTALA Technical Advisory Group. In the case of specialty hospitals, we also believe that **specialty hospitals should disclose to their patients upfront that if complications occur outside their limited capability, patients will be transferred to another hospital**.

- **The ability to deal with emergencies.** Current COP requirements related to emergency services should be strictly enforced. Hospitals that do not offer emergency services are required nonetheless to ensure that they have the ability to appraise emergencies, initially treat, and refer when appropriate. This requires more than simply dialing 911 and waiting for an ambulance to arrive. Hospitals that do offer emergency services (whether by choice or by state requirement) should be required to fully meet the provisions of 42 CFR 482.55. As was identified by MedPAC in its March 2005 report, some specialty hospitals have what they call an emergency department in order to meet state licensure requirements but, given MedPAC's description of what they found, some of those hospitals cannot possibly be in compliance with the provisions of Sec. 482.55. If a hospital holds itself out as having emergency services, that proffer must be real or the public's health and safety will be endangered.

- **A fully-functioning discharge planning process and relationships with post-acute providers in the community**. NJHA believes this is especially important for Medicare beneficiaries given CMS's finding that limited-service hospitals have shorter lengths of stay and higher readmission rates. While discharge planning is required of all hospitals, those findings suggest that some limited-service hospitals may have inadequate discharge planning processes and, as a result, Medicare patients are being sent home too quickly or without adequate post-discharge support.

We would urge caution, however, with respect to how CMS judges whether a hospital is primarily engaged in providing services to inpatients. The delivery of health care has changed significantly in the forty years since Medicare was enacted. Many hospitals are now health care systems that provide a wide range of inpatient and outpatient care. **NJHA recommends that CMS look at a hospital's operation comprehensively to ascertain whether the facility is *significantly* (or *seriously* if you will) engaged in providing inpatient hospital care and avoid adopting any rigid standard for the proportion of inpatient versus outpatient care**. There is a significant difference between a hospital with 278 hospital beds that has 14,400 inpatient discharges and 94,500 hospital inpatient days a year that provides almost 80 percent of its care to outpatients because of the scope of services, and a limited-service hospital with 8 beds, only 537 discharges and 1,200 hospital inpatient days a year that also provides almost 80 percent of its care to outpatients. The fact that most surgical and orthopedic hospitals' performance could not be measured due to insufficient numbers of inpatient discharges is telling.

CMS also should consider whether the inpatient component of the hospital, even if small, represents a vital health care resource as in the case of a small rural hospital or a highly specialized center of excellence.

Treatment of Specialty Hospitals During the Review Process. NJHA was surprised to see in the June 9 notice that CMS would not be applying the suspension of the enrollment process for specialty hospitals across the board. Despite the fact that many specialty hospitals have had their applications pending during review of whether they were eligible for grandfathering under the moratorium, it is difficult to understand how CMS plans to act on those applications when it has not yet completed its review of standards and the enrollment process. Consequently, **NJHA recommends that CMS apply the suspension of processing enrollment applications for all specialty hospitals until its review is completed and appropriate revisions adopted.**

As indicated in AHA's May 24 letter to the Administrator, the **AHA recommends that CMS use its authority granted under 1861(e)(9) and 1877(d)(3) of the Social Security Act to extend the application of the moratorium's conditions for grandfathering of existing physician-owned limited-service hospitals until CMS completes its review and Congress acts on pending legislation regarding self-referral to physician-owned limited service hospitals. The NJHA supports AHA's recommendation.** In addition to overall patient health and safety concerns, there are several important reasons for CMS to administratively extend the application of the growth limitations under the moratorium:

- It would maintain the status quo while CMS conducts its review and Congress is deciding what action it will take.

- It would avoid any significant growth in volume prior to implementation of expected payment changes.

- It would avoid unnecessary administrative complications that could arise if currently grandfathered hospitals take significant steps to grow or change when there is a possibility that Congressional action will reach back to the June 8 sunset of the original moratorium.

428

BODDEN
KRUSHAT
HEFTER
HARTSTEIN

CMS-1500-P-760

Submitter : Ms. Leisa MaGill **Date:** 06/24/2005

Organization : Self Regional Healthcare

Category : Other Health Care Professional

Q DATA

Issue Areas/Comments

GENERAL

GENERAL

The following statments are in regards to the Data Validation Process of the Quality Indicators:
Data Validation

? The parameters of the validation process should be stated explicitly and documented. This includes clear definitions, all applicable skip logic, all edits or audits to be applied, and other related information. Hospitals must know exactly what is being validated so they may adhere to the specifications during the data collection process. Under the current process, by the time hospitals receive feedback on one quarter?s validation, they have already moved onto the next quarter?s data collection and can not make changes quickly enough to impact the next quarter. If the validation specs and requirements were clear and well- documented, hospitals could be proactive. Any changes must be communicated clearly and within a timeframe sufficient for hospitals to react and changes their attendant processes. Premier proposes that any modifications to the technical processes be published 120 days prior to the effective/implementation date.

? Premier believes that the validation process should incorporate only data associated with the ten specified measures. Under the current system, a hospital that submits multiple data sets may earn an overall quality score of 80 percent; however, if errors occur more frequently in the subset required for the annual payment update, the quality of such data may be considerably lower. In this way, payments risk being based on inconsistent calculations and inaccurate data.

? Further, Premier believes that hospitals should be notified of any validation rule changes at least 120 days prior to the hospital data abstraction period. The validation rules applied by CMS as of June 6, 2005 are, in fact, retroactive to the July?September 2004 data. CMS validated the three test LDL measures for the AMI clinical focus group. Consequently, hospitals are receiving mismatches for not collecting this optional data. The validation documentation for the July 1, 2004 discharges is dated April 29, 2005. Since the data was submitted at the end of January, hospitals have not had sufficient time to make the appropriate change.

? Under the proposed rule, CMS only allows ten days for a hospital to appeal its validation; however, the agency fails to specify whether the reference is to ?business? or ?calendar? days. Premier believes that neither case offers sufficient time for hospitals to respond. Therefore, we propose allowing hospitals 30 calendar days to appeal their validation findings.

? Many Premier hospitals report having received inconsistent communications relating to the ?data reporting for annual updates? provision of the Medicare drug law (MMA). Premier believes that all communications and directives regarding this initiative should be centralized and disseminated to all stakeholders (hospitals, vendors, and QIOs) simultaneously. Such a strategy would simplify and standardize message generation. It would also eliminate the confusing and often contradictory communications typical of the current process, which requires state QIOs to interpret a given communication before forwarding it to hospitals.

429

COLLINS
MOREY
SMITH
HEFTER
HARTSTEIN

CMS-1500-P-764

Submitter : **Mr. Steve Barnett** **Date: 06/24/2005**

Organization : **Harbor Beach Community Hospital**

Category : **Critical Access Hospital**

CAH/RELOC

Issue Areas/Comments

GENERAL

GENERAL

Critical Access Hospitals

I am writing in opposition to the proposed inpatient hospital rule that would prevent most Critical Access Hospitals (CAH) from rebuilding their facilities more than 250 yards from their current location.

As of January 1, 2006, section 405 of the Medicare Modernization Act discontinues the 'necessary provider' status option, which allows states to waive the location requirement of the CAH program. As the president of a CAH that was designated as such using the necessary provider language, my facility will be in jeopardy of losing its CAH status if the changes, which are included in the fiscal year 2006 proposed inpatient PPS rule, are implemented. The proposal would bar me, as a CAH with necessary provider status, from rebuilding my facility anywhere other than my current location unless the project was under development before December8, 2003. I understand the need to maintain CAH facilities in specific service areas, yet the 250 yard rule seems arbitrary and should be replaced with a more flexible rule that allows for modernization.

My facility is the sole provider of inpatient acute-care services, outpatient services, and we offer long-term care services in our community. The CAH program has afforded us with an effective reimbursement system that has allowed us to continue providing health care in our community. If we lost our CAH status the effect would most likely be devastating.

In our case we have an 80 year old building, are landlocked, and despartely need to rebuild so that current hospital practices can be employed. As you might imagine my ability to upgrade, improve quality, and occupational safety will require more flexibility than has been provided for.

The law explicitly grandfathers existing CAH programs with construction projects under development before December 8, 2003. I believe CMS should consider other options that allow more flexibility for CAHs who might not meet the deadline. Maintaining the current 250 yard requirement is not appropriate to meet my needs or the patients we serve. As a necessary provider CAH I should be allowed to relocate as appropriate to improve the care in my community. I urge CMS to remove the proposed restrictive date requirements and establish reasonable criteria to ensure that I can move within my service area without penalty.

430

WALZ
HART
HEFTER
HARTSTEIN

Submitter : Mr. GB (Sam) Serrill

Date: 06/24/2005

Organization : Wesley Medical Center

Category : Hospital

TRANSFERS

Issue Areas/Comments

GENERAL

GENERAL

We are opposed to this regulation which will expand the post acute care transfer policy from 30 DRG's to 231 DRG's. This policy is not in the best interests of patients and providers. It undercuts the basic principles and objectives of Medicare's PPS and undermines clinical decision-making. It also penalizes hospitals for providing efficient care at the most appropriate time and in the most appropriate setting.

CMS-1500-P-795

431

MILLER
HEFTER
HARTSTEIN
Seifert
Knight
WALZ
HART
Kraemer

Submitter : Ms. Kyle Ballou

Organization : Yale New Haven Health System

Category : Hospital

Date: 06/24/2005

WI/Bd
Labor/S
Transfer
Impact
MB/H

Issue Areas/Comments

GENERAL

GENERAL

June 24, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sir or Madam:

On behalf of Yale New Haven Health System, comprised of Bridgeport Hospital, Greenwich Hospital and Yale-New Haven Hospital, I am writing in opposition to the proposed rule: Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates [CMS-1500-P].

Specifically, YNHHS is concerned with the provisions that seek to reduce the labor-related share from 71.1 percent to 69.7 percent for hospitals located in areas with a wage index greater than 1.0; and the transfer policy expansion.

The proposed change to the wage index will primarily hurt urban hospitals for the benefit of rural hospitals. This does not make sense as urban hospitals, such as those in our health system, have experienced a steady increase of uninsured, underinsured, and Medicaid patients over the past several years. Our System hospitals simply cannot afford these reductions. In an industry in which a positive operating margin of four percent is considered necessary to operate effectively, a 2003 study by the National Association of Urban Hospitals found that among hospitals that qualify for Medicare DSH payments, the collective financial performance of urban hospitals nationwide is 25 times worse than that of rural hospitals.

The proposed transfer policy expansion penalizes hospitals that ensure that Medicare patients receive care in the most appropriate setting and undermines the PPS system. If all short stay cases are removed, then the average DRG payment is no longer the average. In addition, the dollars that are removed are not added back to the standardized rate to compensate for the resulting longer LOS of the remaining cases.

The anticipated impact of these two proposed policy changes on each of our System hospitals for FY2006 is:

	Transfer Policy Expansion	Labor Share Decrease	Total Impact
Bridgeport Hospital	($670,000)	(250,700)	(920,700)
Greenwich Hospital	(466,000)	(107,400)	(573,400)
Yale-New Haven Hospital	(2,635,000)	(548,800)	(3,183,800)
		Total System Impact:	($4,677,900)

YNHHS is concerned that these provisions will result in ongoing financial harm to our hospitals that serve as the safety net for our community. Therefore, I ask that CMS not reduce the labor-related share of the Medicare wage index, nor expand the transfer policy.

I also ask that CMS consider a minimum guaranteed rate increase of 2% for hospital providers and a one-time increase of 3.8% to correct for the consistent under-forecasting of the hospital market basket that occurred in seven of the last eight years. Granting such an increase, while not correcting for the past under-funding, will offer great relief by bringing the current rates to their proper level. Setting a minimum increase of 2% will prevent what happened last year when 48 hospitals in the country, including Bridgeport, Greenwich and Yale-New Haven Hospitals, were paid less in 2005 than in 2004; 14 of the 48 were in Connecticut. If these various proposed changes go into effect for FY2006, nine hospitals in Connecticut will receive less in 2006 than they did in 2005, including Bridgeport and Yale-New Haven Hospitals. We believe CMS should develop and implement a minimum increase for hospitals similar to that developed for Health Plans (i.e. 2% minimum annual increase.)

YNHHS appreciates your consideration of these comments.

Sincerely,

Kyle L. Ballou, Esq.
Administrative Director
Community & Government Relations
Yale New Haven Health System

CMS-1500-P-795-Attach-1.DOC

Attachment to #795

June 22, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sir or Madam:

On behalf of Yale New Haven Health System, comprised of Bridgeport Hospital, Greenwich Hospital and Yale-New Haven Hospital, I am writing in opposition to the proposed rule: Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates [CMS-1500-P].

Specifically, YNHHS is concerned with the provisions that seek to reduce the labor-related share from 71.1 percent to 69.7 percent for hospitals located in areas with a wage index greater than 1.0; and the transfer policy expansion.

The proposed change to the wage index will primarily hurt urban hospitals for the benefit of rural hospitals. This does not make sense as urban hospitals, such as those in our health system, have experienced a steady increase of uninsured, underinsured, and Medicaid patients over the past several years. Our System hospitals simply cannot afford these reductions. In an industry in which a positive operating margin of four percent is considered necessary to operate effectively, a 2003 study by the National Association of Urban Hospitals found that among hospitals that qualify for Medicare DSH payments, the collective financial performance of urban hospitals nationwide is 25 times worse than that of rural hospitals.

The proposed transfer policy expansion penalizes hospitals that ensure that Medicare patients receive care in the most appropriate setting and undermines the PPS system. If all short stay cases are removed, then the average DRG payment is no longer the average. In addition, the dollars that are removed are not added back to the standardized rate to compensate for the resulting longer LOS of the remaining cases.

The anticipated impact of these two proposed policy changes on each of our System hospitals for FY2006 is:

	Transfer Policy Expansion	Labor Share Decrease	Total Impact
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Yale-New Haven Hospital	(2,635,000)	(548,800)	(3,183,800)
			($4,677,900)

YNHHS is concerned that these provisions will result in ongoing financial harm to our hospitals that serve as the safety net for our community. Therefore, **I ask that CMS not reduce the labor-related share of the Medicare wage index, nor expand the transfer policy.**

I also ask that CMS consider a minimum guaranteed rate increase of 2% for hospital providers and a one-time increase of 3.8% to correct for the consistent under-forecasting of the hospital market basket that occurred in seven of the last eight years. Granting such an increase, while not correcting for the past under-funding, will offer great relief by bringing the current rates to their proper level. Setting a minimum increase of 2% will prevent what happened last year when 48 hospitals in the country, including Bridgeport, Greenwich and Yale-New Haven Hospitals, were paid less in 2005 than in 2004; 14 of the 48 were in Connecticut. If these various proposed changes go into effect for FY2006, nine hospitals in Connecticut will receive less in 2006 than they did in 2005, including Bridgeport and Yale-New Haven Hospitals. We believe CMS should develop and implement a minimum increase for hospitals similar to that developed for Health Plans (i.e. 2% minimum annual increase.)

YNHHS appreciates your consideration of these comments.

Sincerely,

Kyle L. Ballou, Esq.
Administrative Director
Community & Government Relations
Yale New Haven Health System

432

COLLINS
MOREY
SMITH
HEFTER
HARTSTEIN

Submitter : Steven Moburg **Date:** 06/24/2005

Organization : Paynesville Area Health Care System

Category : Health Care Professional or Association

CAH/Reloc

Issue Areas/Comments

GENERAL

GENERAL

I urge you to oppose the Medicare Construction Ban on Critical Access Hospitals. It was never the intent of Congress that a CAH facility be prohibited from replacing or relocating their facility. In our case, the facility is 39 years old, in what is now a residential area, where little expansion is possible.
In December of 2003, we were concerned about our own financial survival, and looking for ways not to extend ourselves in further debt. As we continue to improve our financial position, we would like the same opportunities as other facilities to plan for needed expansion and/or replacement options.
I believe this arbitrary date restriction is overreaching the original authority of CMS, and the intent of the Medicare Modernization Act, and should therefore be opposed.
Thank you for your consideration.

Steven T. Moburg, CEO
Paynesville Area Health Care System

433

~~KNIGHT~~
~~[redacted]~~
HEFTER
HARTSTEIN
Bodden
M. HAMMEL

CMS-1500-P-815

Submitter : **Mr. Ken Koopman** **Date: 06/24/2005**

Organization : **Health Management Associates, Inc.**

Category : **Health Care Professional or Association**

~~MB/HI~~ Q DATA

Issue Areas/Comments

GENERAL

GENERAL

Regarding the Hospital Quality Data proposal, CMS should delaying implementation of the propsal to determine a hospitals market basket update based on it's chart audit validation score. There is much confusion with the entire process. The state QIO's are confused and they are often providing incorrect and confusing information to hospitals. The initial release of the 3rd quarter date was retracted. We understand that a third release has just been issued. It still contains errors. Everyone wants reliable data. Hospitals want to provider reliable data. There's just been a lot of confusing and lack of instruction regarding the entire process. CMS should consider the burdent the process places on rural hospitals. The apropriate thing to do is delay implementation until FY 2007 of the proposal and provided QIO's and hospitals with adequate notice and instruction. CMS should also inform providers of their intentions to tie future payments to quality measurement score. In the future, how does CMS intend to reimburse providers with regards their quality measurement scores? For FY 2006, the appropriate thing to do is to delay implementation of the proposal until everyone has been adequately informed. Thank you for your consideration.

434

COLLINS
MOREY
SMITH
HEFTER
HARTSTEIN

Submitter : Mrs. Joan Walters

Organization : Prague Municipal Hospital

Category : Critical Access Hospital

CAH/RELOC

Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

6-24-05
RE: Critical Access Hospital - Proposed Rule Comments
I am the administrator of a small rural hospital in Oklahoma.
The recent proposed rule from CMS provides that any Critical Access Hospital (CAH) designated as a necessary provider (NP) by the State is prohibited from building a replacement facility unless: (1) It's within 250 yards or on land owned before 12/08/03. (2) Construction plans were started before 12/08/03, and (3) the new facility will provide care to at least 75% of current patients using at least 75% of existing staff (75% rule). Our facilty is in need of replacement and the first two requirements of this rule would prohibit this need being fulfilled. The initial portion of our facility was built in approximately 1952 and is still utilized on a daily basis. There were subsequent additions in the mid 1960s and mid 1970s. There is a great need for our facility to rebuild. It is no longer an efficient facility and physically is not of the state-of-the-art quality that we would like to be able provide for our patients. We have no available grounds within the 250 yard proposal that has any potential for rebuilding. Our current facility is in the middle of a residential area with no spare grounds except for a small parking lot. The condition of having construction plans before 12/08/03 is also unrealistic as we are under our third ownership in less than one year's time, and only our new owner has expressed an interest in building an updated facility, even though this has been a great need for quite some time. CAH designation is crucial to the survival of our hospital. It is also already difficult enough to recruit and retain high quality physicians to a rural area without having an outdated facility that will squelch any interest they might have. Rural America deserves quick access to quality health care as much as those in metropoliton areas. It is especially a hardship for the elderly as they often have limited support systems and are afraid to drive in the larger cities. I feel these proposals would work directly against their rights to these services.
The estimates that have been made that replacement hospitals would cost $25 - $35 million is also grossly exaggerated. I ask that you take into serious consideration to not allow implementation of this proposed rule - it would be devastating to the future of our hospital and community.
Sincerely,
Joan Walters, RN, BSN
CEO Prague Municipal Hospital
Prague, OK

435

BROOKS
FAGAN
GRUBER
KELLY
HUE
HEFTER
HARTSTEIN

CMS-1500-P-855

Submitter : **Ms. Kristine Becker** **Date: 06/24/2005**

Organization : **Sacred Heart Medical Center**

Category : **Hospital**

DRG/GEN

Issue Areas/Comments

GENERAL

GENERAL

June 24, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS?1500?P
P.O. Box 8011
Baltimore, MD 21244?1850.

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates

My association is Sacred Heart Medical Center

As the Director of the Cardiac Service Line that provide care to over 4,000 elctrophysiology patients a year, I am writing to express my concern with the proposed rule, " Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates?, published by the Centers for Medicare and Medicaid Services (CMS) on April 25, 2005. My concern is on page 50 of the proposed rule where CMS proposes to modify the DRGs for ICD implants.

On page 50 of the proposed rule CMS provides an analysis showing the three ICD DRGs with and without hospital procedure code 37.26. The problem with the analysis is hospital procedure code 37.26 contains three separate procedures, of varying intensity: electrophysiology study, intraoperative device interrogation and non-invasive programmed stimulation. This means code 37.26 represents a coding problem (three very different codes in one) ? not a payment problem. Until the coding issue is addressed, the real impact on payment can not be determined. Currently there is no data on how the three procedures vary with respect to hospital charges. In a meeting attended by industry, CMS coding experts acknowledged that the structure of hospital procedure code 37.26 results in flawed charge data.

The payment change CMS proposes would have a severe financial impact on my hospital ? without data to justify the change. This is particularly true for CRT-D devices which are ICDs that addresses both Sudden Cardiac Death and heart failure and cost more than single purpose ICDs. CMS says it is not appropriate to have all three procedures in code 37.26 drive to higher paying DRGs. It is equally inappropriate to have all three drive to lower paying DRGs.

I respectfully request that CMS withdraw the proposed ICD DRG revision and address this coding problem, with a coding solution, before attempting to make detrimental changes to the current defibrillator DRG structure that would hurt my hospital. If you proceed with this change in coding, our analysis indicates that our program to offer this life-saving device will be jeopardized. Please reconsider.

Thank you for your consideration.

Sincerely,

Kristine F. Becker, RN, MHA, CNA
Director, Cardiac Service Line
Assistant Vice President, Nursing Informatics
Sacred Heart Medical Center
PO BOX 2555
Spokane, WA 99220-2555
509 474-7126 (desk)
509 880-5581 (pager)
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beckerk@shmc.org

Submitter : Mr. Stephen Harwell **Date:** 06/23/2005

Organization : Healthcare Association of New York State

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attached comments from the Healthcare Association of New York State.

CMS-1500-P-662-Attach-1.DOC

Transfers
CBSA
WI/Gen
MB/H
MB/Ex Hosp
Pymt Rates/outliers
Geo Reclas
Out-M
CAH/Reloc
SP H
Med PAC

Hafler
Hartstein
Walz
Treitel
Miller
Seifert
Knight
Ellingson
T. Jones
Kenly
Collins
Morey
Smith
ROMANO

Attachment to #662

Healthcare Association
of New York State

June 23, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1500-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1500-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule

Dear Dr. McClellan:

The Healthcare Association of New York State (HANYS), on behalf of our more than 550 hospitals, nursing homes, home health agencies, and other health care providers, welcomes the opportunity to comment on the proposed rule related to the Medicare Prospective Payment System (PPS) for inpatient admissions.

POST-ACUTE CARE TRANSFERS

CMS proposes to expand the post-acute care transfer policy from 30 DRGs to 231 DRGs. HANYS opposes this proposal.

The law gives CMS authority to expand the number of DRGs for FFY 2001 and subsequent years. However, the law specifies that DRGs be selected based upon a high volume of discharges to post-acute care and a disproportionate use of post discharge services. The proposed criteria fail to carry out this requirement. The proposed expansion of the policy to cover 231 DRGs goes far beyond those DRGs with a disproportionate use of post-discharge services.

In the proposed rule, CMS says "[T]he purpose of the IPPS transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment." The proposal results in expansion of the policy to many DRGs where there is no evidence that hospitals are changing behavior to take advantage of the payment system.

In this proposal, CMS makes substantial revisions to the DRG selection criteria with little justification or evidence. The revised criteria do not address specific changes in hospital behavior that might indicate an attempt to take advantage of the payment system. Moreover, they would not result in more equitable payments. For all practical purposes, such an extensive expansion of the post-acute transfer policy acts as an across-the-board reduction in

Medicare payments. As a result, hospitals would be penalized for providing efficient care in the setting that is most appropriate for the patient.

HANYS opposes the expansion of the post-acute care transfer policy, which is not in the best interests of patients or caregivers. It undercuts the basic principles and objectives of the Medicare PPS, undermines clinical decision-making, and penalizes hospitals for providing efficient care, at the most appropriate time and in the most appropriate setting.

CBSAs – WAGE INDEX

In FFY 2005, CMS implemented revised wage areas based on Core-Based Statistical Areas (CBSAs). This change had a significant redistributional impact with many areas experiencing substantial increases or decreases in their wage adjustment. As a result, CMS provided a blended wage index in FFY 2005 for hospitals that were harmed by the redefinition of wage index areas. Hospitals that would have received a higher wage index under the prior geographic area definitions were provided a blended wage index combining 50% of the wage index based on the new definitions and 50% based on the old definitions. CMS proposes to end this protection and determine 100% of the wage index based upon the new CBSA configurations beginning in FFY 2006.

The New York Metropolitan Statistical Area was one area that experienced a substantial wage index decrease due to the new definitions. In our comments on the FFY 2005 proposed rule, HANYS objected to the revision of the New York MSA. Our letter provided evidence showing that the proposed revision to the New York MSA is inappropriate and inequitable. The redefinition of the New York City wage area was recently upheld by the federal District Court decision in Bellevue Hospital Center v. Leavitt. However, CMS notes that an appeal of this decision had not yet been heard. CMS states that uncertainty over whether the decision would be appealed was a factor in the decision to maintain the occupational mix adjustment at the FFY 2005 level. We believe that CMS should apply this same logic in the case of the wage area definitions and continue to apply a blend of 50% of the wage index based on the new definitions and 50% based on the old definitions for hospitals that were harmed by the redefinition of wage index areas in FFY 2006.

HOSPITAL MARKETBASKET

The hospital update is based on a "marketbasket" factor that is intended to reflect the average change in the price of goods and services hospitals purchase to furnish inpatient care. These price changes must be projected forward to estimate increases for the subsequent year so that an appropriate marketbasket update can be determined in advance of payment. The payment system is prospective, and the update is not retroactively reconciled to reflect actual price increases for the year. Therefore, a reliable projection methodology is vital to ensure equitable payments.

In recent years the projection has been consistently and materially lower than the actual increase. The actual increase in FFY 2003 was 3.9% while the projected increase was 3.5%. In FFY 2004 the actual was 3.8% compared to a 3.4% projection. CMS reports that, based on the most recent data, the FFY 2005 marketbasket increase is now estimated to be 4.1% compared to the projected 3.3% increase that was used to determine the update factor. We are concerned that the methods used to project the marketbasket

increase are flawed and fail to provide a reliable estimate of hospital cost increases. Given a 4.1% cost increase for FFY 2005, a projected FFY 2006 increase of 3.2% does not seem reasonable. We request that CMS review the methodology that was used to determine the projected FFY 2005 marketbasket and make details of the calculation available to the public.

EXCLUDED HOSPITAL MARKETBASKET

Children's hospitals and cancer hospitals are currently reimbursed using the excluded hospital marketbasket. CMS contends that the FFY 2002 cost weights for children's and cancer hospitals are closer to those used in the inpatient PPS marketbasket than those used in the excluded hospital marketbasket. Therefore, CMS is proposing to use the inpatient PPS operating marketbasket percentage increase to update the target amounts for children's and cancer hospitals.

Children's and cancer hospitals should continue to use the exempt hospital marketbasket until after a decision is made on the development of a separate marketbasket for other exempt facilities. The data for children's and cancer hospitals are included in the current exempt hospital marketbasket and the updates for these hospitals should continue to be determined based on that marketbasket. If new marketbaskets for the IRFs, IPFs, and LTCHs are implemented, a subsequent proposal for the children's and cancer hospitals can be made. Any such proposal should include a more detailed analysis of the cost structures of these hospitals.

HOSPITAL MARKETBASKET - FREQUENCY OF UPDATES TO THE MARKETBASKET

CMS is proposing to rebase the hospital marketbasket every four years. Under the proposal, the marketbasket would be rebased for FFY 2006 and the next rebasing would occur in FFY 2010. The last rebasing of the marketbasket was implemented in FFY 2003. If the CMS proposal for a four-year interval were applied, the next update would be in FFY 2007. However, CMS proposes to update the marketbasket for FFY 2006. There is no compelling reason for a FFY 2006 update. There is no new census data available and CMS cites no immediate problem that must be addressed. Instead, CMS should follow the four-year schedule and implement the next update in FFY 2007. Moreover, this fits much better with the schedule for the release of the data that is used in the calculation. CMS provided the following table in the proposed rule:

Chart 9: Expected Future Data Availability for Major Data Sources used in the Hospital Market Basket

PPS FY Update	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Market Basket Base Year	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Medicare Cost Report Data Available	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
I-O Data Available	1997	1997	1997	1997	1997	2002
BES Data Available	1997	1997	1997	1997	1997	2002
Number of Years Data Must Be Aged	5	6	7	8	9	5

FPS FY Update	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Market Basket Base Year	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Medicare Cost Report Data Available	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
I-O Data Available	2002	2002	2002	2002	2007
BES Data Available	2002	2002	2002	2002	2007
Number of Years Data Must Be Aged	6	7	8	9	5

According to this schedule, the next time that a full update of the required Bureau of Economic Analysis' Benchmark Input-Output (I–O) tables and Bureau of the Census' Business Expenses Survey (BES) data will be available is FFY 2011. Therefore, it makes little sense to do marketbasket updates in FFY 2006 and FFY 2010 as proposed. An update in FFY 2010 would require the use of 1997 I–O tables and 1997 BES data. At that point this data would be badly out of date and would need to be "aged" by nine years. It would also mean that there would be no update in FFY 2011, the first year that the 2002 I-O tables and BES data would be available.

CMS should not rebase the marketbasket in FFY 2006. Instead, CMS should implement the proposed four-year schedule for marketbasket rebasing with the next update occurring in FFY 2007 and the subsequent update in FFY 2011.

LABOR-RELATED SHARE

CMS proposes a revised calculation of the labor-related share of the PPS rate. This would result in a decrease in the labor-related share from 71.066% to 69.731%. HANYS opposes the proposed revision.

In the inpatient PPS rule for FFY 2003, CMS examined the methodology used to determine the labor-related share. The CMS calculation of the labor-related share for FFY 2003 resulted in an increase from 71.066% to 72.495%. However, CMS did not implement the increase pending further research to determine whether a different methodology for determining the labor-related share should be adopted. In the FFY 2006 proposed rule, CMS discusses continuing research on alternative methodologies for calculating the labor-related share. However, CMS states that the analysis has not yet produced sound enough evidence to propose a change and that they will continue to study the issue. We believe that it is inequitable to decline the implementation of a labor-share increase in FFY 2003 pending an analysis of the methodology and then propose a labor-share decrease in FFY 2006 while that analysis is still incomplete.

In addition to updating the data, CMS proposes to eliminate postage costs from the labor-related share because they no longer believe that these costs meet the definition of labor-related. CMS does not provide any evidence or analysis to support this belief. HANYS opposes the elimination of postage from the labor-related costs. CMS should not select a single cost category and make a decision in isolation. Instead, any proposed revision should be based on a comprehensive analysis of all cost categories to determine those costs that vary with local market conditions. The analysis should not focus only on the costs that are currently considered to be labor-related. It should also look at costs that are not currently included in the labor-related share to determine if any of these are influenced by the local market area. For example, professional liability insurance is not currently included as a labor-related cost. However, these costs are included in wage-related costs for the wage index calculation and they are locally determined. When CMS revises the components of the labor-related share, professional liability insurance should be included as a labor-related cost.

CMS should maintain the related share at 71.066% pending completion of a comprehensive analysis of the calculation.

OPERATING PAYMENT RATES - OUTLIER PAYMENTS

CMS is proposing to establish a fixed-loss cost outlier threshold for FFY 2006 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $26,675.

The proposal increases the threshold from $25,800 in FFY 2005 to $26,675 in FFY 2006. However, CMS estimates that actual FFY 2004 outlier payments were 3.5% of total payments and that projected FFY 2005 outlier payments are 4.4% of total payments. Given the shortfall in the prior two years compared to the 5.1% target for outlier payments, we are concerned that the proposed threshold increase will result in another year of underpayments.

We urge CMS to adopt the alternative calculation provided by the American Hospital Association (AHA) in their comment letter and set the FFY 2006 threshold at $24,050.

GEOGRAPHIC RECLASSIFICATIONS – MULTI-CAMPUS HOSPITALS

Currently, it is not possible for a facility that is part of a multi-campus hospital with a single cost report to supply wage data in support of a reclassification application for the individual hospital campus. CMS proposes to allow a campus of a multicampus hospital system that wishes to seek geographic reclassification to report campus-specific wage data using a supplemental Form S-3 for purposes of the wage data comparison. We support this proposal that will provide equitable treatment for these hospitals under the reclassification rules.

GEOGRAPHIC RECLASSIFICATIONS - RURAL-URBAN COMMUTING AREAS

Urban hospitals can apply for rural designation based on specified criteria. One of the criteria allows redesignation if the hospital is located in a rural census tract that is part of an urban area. This is determined using the most recent version of the "Goldsmith Modification" as determined by the Office of Rural Health Policy. CMS proposes to revise the regulations to use an updated version of the Goldsmith Modification called Rural-Urban Commuting Area codes (RUCAs). We urge CMS to provide grandfather status to protect hospitals that were redesignated as rural based on the old Goldsmith Modification criteria and no longer qualify under the new RUCAs. Loss of rural status would be devastating for many of these hospitals, particularly for CAHs.

GEOGRAPHIC RECLASSIFICATIONS – GROUP APPEALS

HANYS joins the AHA is recommending a change in policy regarding group reclassifications that are affected by the timing of Section 508 of the MMA. In several instances, hospital groups will be prevented from reclassifing for 2007 because there is a Section 508 hospital in the county that cannot join the group without foregoing its more beneficial Section 508 reclassification. We do not believe that Congress intended for Section 508 hospitals to prevent group reclassifications. We urge CMS to allow Section 508 hospitals to commit to a group reclassification and be considered as a member of the group for the determination of the reclassification request, but allow them to retain their Section 508 reclassification and accept the group reclassification after the Section 508 funding expires.

OUT-MIGRATION ADJUSTMENT

Hospitals cannot receive an out-migration adjustment if they have already received a reclassification. Therefore, if a hospital has an existing reclassification, that hospital must withdraw its reclassification within 45 days of the publication of the proposed rule to receive the out-migration adjustment instead. Because of significant changes to the wage index that took place in FFY 2005, CMS allowed hospitals to withdraw or reinstate their geographic reclassification applications within 30 days of the publication of the FFY 2005 Final Rule. By doing so, CMS acknowledged that changes made between the proposed and final rules could affect whether a hospital was better off accepting the out-migration adjustment or maintaining the geographic reclassification.

There were several revisions to the wage index data subsequent to the publication of the proposed FFY 2006 rule. In addition, CMS has proposed changes to the wage index calculation that may or may not be adopted in the final rule. Given this uncertainty, HANYS requests that CMS implement a policy similar to last year's and allow hospitals to withdraw or reinstate their geographic reclassification applications within 30 days of the date that the final rule is published.

CRITICAL ACCESS HOSPITALS - NECESSARY PROVIDER RELOCATIONS

CMS proposes to establish a methodology to be used by all CMS Regional Offices in making decisions concerning relocations of Critical Access Hospitals (CAHs) with necessary provider designation. CMS policy holds that the necessary provider designation does not automatically follow the provider if the facility relocates to a different location because it is no longer furnishing services to patients in the area that was originally determined to need a necessary provider.

The rule would allow hospitals to rebuild within 250 yards of their existing site or relocate onto a contiguous piece of property if it was purchased by December 8, 2003. For a hospital that moves any further, the hospital will have to submit an application prior to January 1, 2006; showing that at the relocated site:

- it meets the same criteria for necessary provider status that it did when it originally qualified;
- it serves the same community (75% of the same population, 75% of the same services, 75% of the same staff);
- it complies with the same conditions of participation; and
- the relocation plan was "under development" as of December 8, 2003.

This proposal would severely restrict the ability of CAHs designated as necessary providers to replace their existing facilities. First, the 250 yard limit is overly restrictive. We urge CMS to consider any CAH that moves within five miles to be rebuilding and not relocating.

HANYS is also concerned by the requirement that property must have been purchased and plans must have been undertaken prior to December 8, 2003. This will make it impossible for many CAHs to relocate in the future as their physical plants age or market conditions change. The December 8, 2003 deadlines should be eliminated.

In addition, the requirement that the CAH provides 75% of the same services to 75% of the same service area with 75% of same staff would unnecessarily curtail service changes intended to benefit the community. The focus should be on ensuring that the CAH still provides services to the same community. CMS should eliminate requirements based on providing the same services with the same staff. These requirements would hinder hospital modifications intended to adapt to changes in the needs of the community. CMS should only require that the CAH demonstrate that it will provide services to the same community in the new location. This could be demonstrated based on providing services to 75% of the same service area, but flexibility should be provided to take individual circumstances into account.

SPECIALTY HOPSITALS

CMS, in addressing issues regarding physician-owned specialty hospitals, states that an institution must be primarily engaged in furnishing services to inpatients in order to be a Medicare-participating hospital.

HANYS is concerned that a broad application of the definition of a hospital as "primarily engaged in furnishing services to inpatients" could result in difficulties for other hospitals that are not physician-owned. Many non-profit full-service hospitals provide a substantial portion of their services on an outpatient basis.

HANYS urges that CMS consider the suggestions in the AHA letter regarding this issue. CMS should not apply a definition based solely on whether a hospital is primarily engaged in providing services to inpatients. Instead, CMS should look at a hospital's operation comprehensively to ascertain whether the facility is significantly engaged in providing inpatient hospital care and avoid adopting any rigid standard for the proportion of inpatient versus outpatient care. CMS should consider whether the inpatient component of the hospital, even if small, represents a vital health care resource as in the case of a small rural hospital or a highly specialized center of excellence.

MEDPAC RECOMMENDATIONS

In the proposed rule, CMS responds to the Medicare Payment Advisory Commission (MedPAC) recommendations regarding physician-owned specialty hospitals including a recommendation that CMS improve payment accuracy in the hospital inpatient PPS by refining the current DRGs to more fully capture differences in severity of illness among patients. One option that is discussed is the use of alternative DRG systems such as the all patient refined diagnosis related groups (APR-DRGs) in place of Medicare's current DRG system.

HANYS has long supported the adoption of a refined DRG system such as the APR-DRGs. The APR-DRGs have a greater number of DRGs, potentially relating payment rates more closely to patient resource needs. We urge CMS to take positive steps toward the implementation of a refined DRG system as quickly as possible.

Please contact me at (518) 431-7777 or sharwell@hanys.org if you have any questions.

Sincerely,

Stephen Harwell
Director, Economic Analyses
Economics, Finance, and Information

SH:lw

437 KRAEMER HEFTER HARTSTEIN MILLER

Submitter : Mr. Donald Gardner **Date:** 06/24/2005

Organization : Caldwell Memorial Hospital

Category : Hospital

W I/GeN IMPACT

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attention: CMS-1500-P

Re: Determination of ?Wage Related Costs for Overhead Costs of Excluded Areas?

Dear Sir/Madam:

We write to comment on the change in how CMS calculated the area wage index with respect to the calculation of wage related costs (WRC) attributable to the overhead centers for the excluded areas. Currently, CMS has a multi-step process for calculating the proportion of overhead center dollars and hours attributable to the areas excluded from PPS. Essentially, this formula develops a proportion of excluded hours to total hours. Then that proportion is applied to total overhead dollars and hours to calculate the amounts to be removed that are attributable to the overhead centers. CMS has applied a similar but slightly different calculation for removing the WRC related to these overhead areas.

For FY 2006, CMS made a change in deriving the proportion attributable WRC. This year CMS removes certain hours from the total hours (the denominator) in calculating the proportion of WRC to be removed. This causes an increase in the proportion of WRC to be removed. In certain instances this can cause a significant change in the WRC removed and in turn the average hourly wage and area wage index of the affected area. Such is the case for our hospital.

CMS has not discussed this change in its proposed rule nor why this change is being made. CMS appears to have examined in only a limited way the impact of this change. There are certain areas where this change has a material impact on the hospital?s area wage index. These issues have not been discussed in the rule nor have they been considered in its adoption. Given that this change can impact an area quite significantly, it is appropriate that it be discussed and comments requested. Accordingly, the change should not merely be implemented without discussion or comment.

We believe that CMS should not adopt this change for three reasons. First, it has not been proposed in rule making. Second, it represents a significant change for selected areas. Third, the impact does not appear to have been identified in CMS? impact analysis. Accordingly, we recommend that CMS continue with its previous formula as in prior years.

We understand that from time to time CMS may want to make a change in the formulas for calculating the WRC proportion for reasons it might identify. Nevertheless such change needs to be discussed along with the related rationale, proposed in rule making prior to adoption and with the impact of such a change identified and evaluated. From the rule it appears that none of these have been properly performed. Accordingly, CMS should not implement this change and continue with its current formulas.

We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss our comments further, please feel free to contact me.

Sincerely,
Donald Gardner, Jr
Vice President Finance/CFO
Caldwell Memorial Hospital
321 Mulberry Street SW
PO Box 1890
Lenoir, NC 28645

CMS-1500-P-706-Attach-1.PDF

ATTACHMENT TO #706

Caldwell Memorial Hospital
Post Office Box 1890 • 321 Mulberry Street, S.W. • Lenoir, NC 28645-1890 • Tel. (828) 757-5100

June 22, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attention: CMS-1500-P

Re: Determination of "Wage Related Costs for Overhead Costs of Excluded Areas"

Dear Sir/Madam:

We write to comment on the change in how CMS calculated the area wage index with respect to the calculation of wage related costs (WRC) attributable to the overhead centers for the excluded areas. Currently, CMS has a multi-step process for calculating the proportion of overhead center dollars and hours attributable to the areas excluded from PPS. Essentially, this formula develops a proportion of excluded hours to total hours. Then that proportion is applied to total overhead dollars and hours to calculate the amounts to be removed that are attributable to the overhead centers. CMS has applied a similar but slightly different calculation for removing the WRC related to these overhead areas.

For FY 2006, CMS made a change in deriving the proportion attributable WRC. This year CMS removes certain hours from the total hours (the denominator) in calculating the proportion of WRC to be removed. This causes an increase in the proportion of WRC to be removed. In certain instances this can cause a significant change in the WRC removed and in turn the average hourly wage and area wage index of the affected area. Such is the case for our hospital.

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the impact of such a change identified and evaluated. From the rule it appears that none of these have been properly performed. Accordingly, CMS should not implement this change and continue with its current formulas.

We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss our comments further, please feel free to contact me.

Sincerely,

Donald Gardner, Jr
Vice President Finance

cc: Laura Easton
Sandra Farmer
Drew Wood

4380
(3.)

Submitter : Mr. Curt Zimmer

Date: 06/23/2005

Organization : White Memorial Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-670-Attach-1.PDF

Transfers
Labor/S
Q Data

Hefler
Hartstein
Walz
Hart
Seifert
Knight
Treitel
Bodden
M. Hammel

ATTACHMENT TO # 670

White Memorial Medical Center
Adventist Health

1720 Cesar E. Chavez Avenue
Los Angeles CA 90033
323-268-5000

June 23, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Docket ID: CMS-1500-P
P. O. Box 8010
Baltimore MD 21244-1850

VIA www.cms.hhs.gov/regulations/ecomments/

Re: Proposed Changes to Hospital IPPS for FFY 2006

White Memorial Medical Center is very concerned with the proposed IPPS changes to be effective on October 1, 2005.

Post-Acute Care Transfers (PACT) DRGs:

White Memorial Medical Center opposes the expansion of the PACT DRGs from 30 to the proposed 223 on the following basis:

- The Social Security Act statutes that authorized implementation of per diem rates for PACT DRGs states in part that the Secretary could select DRGs "based upon high volume of discharges classified within such groups." As initially implemented, this threshold was defined as 14,000 discharges per year. CMS is now proposing an 85% reduction in the number of discharges within a DRG required to meet this definition. Given that there are far more than 2,000 hospitals in the United States, this new definition of "high volume" means that the average hospital would see less than one discharge per DRG for that DRG to qualify. It does not appear that this new definition meets the intent of Congress to apply PACT payments to "high volume" DRGs.

- The Social Security Act statutes state that in addition to being "high volume", DRGs must demonstrate a "disproportionate use of post discharge services." Given that CMS has identified the range of post acute care setting utilization for DRGs that presently qualify under the PACT to be from 15% to 76% with many of those percentages in well above the 20% threshold, the new 20% criteria appears arbitrary when considered in conjunction with the lowered definition of "high volume."

- The radical expansion of PACT DRGs violates the original premise of the inpatient prospective payment system. The basic concept of DRG PPS is that some cases will be more costly than the average (excluding outliers) and some cases will be less costly (inliers). By including the inlier cases in the calculation of DRG weights and than paying these cases on a per diem basis, CMS is underpaying other than inlier cases.

- The radical expansion of PACT DRGs will likely create an incentive for hospitals to extend the length of stay to at least one day short of the geometric mean length of stay. Since CMS has already implemented PPS payment systems for sub acute levels of care, it should not now adopt payment methods that would unduly influence a patient's level of care.

- The radical expansion of PACT DRGs is unfair to areas of the country that have shorter lengths of stay. Hospitals in these areas will now be penalized with lower reimbursement simply because they may have better practice patterns than areas of the country with longer lengths of stay. This also violates the original premise of DRG PPS which attempted to provide incentives for more appropriate utilization of resources.

- The radical expansion of PACT DRGs placed an undue burden on hospitals to keep track of what happens to a patient after a patient is discharged to another setting with no plan for further treatment.

Labor Related Share:

In support of its proposal to rebase the wage-index labor related share to FFY 2002, CMS compares the FFY 2002 with FFY 1992 but does not draw any conclusions regarding the related shifts by line items. Furthermore, CMS does not make comparisons to or draw conclusions about differences in the labor related share based on FFY 1997 which was initially analyzed for FFY 2002. The FFY 2002 proposal to rebase the labor related share to FFY 1997 would have resulted in an increase to the labor related share, but was ultimately withdrawn. This increase would have benefited those urban facilities with a wage index greater than 1.00.

Therefore, White Memorial Medical Center opposes the proposal to rebase the wage-index labor related share to the FFY 2002 amount for the following reasons:

- The FFY 2002 proposal to rebase the labor related share to FFY 1997 would have resulted in an increase to the labor related share, but was ultimately withdrawn. This increase would have benefited those urban facilities with a wage index greater than 1.00. The proposal to now rebase the labor related share to FFY 2002 decreases the labor related share. Since those facilities with a wage index of less than 1.00 have already been assigned a labor related share of 62%, it appears that CMS is arbitrarily electing to rebase the labor related share only when CMS accrues the financial benefit.

- Had CMS compared the line item elements that make up the labor related share with FFY 1997 data, it would have seen greater variation among the line items than with FFY 1992 analysis. These changes raise questions about:
    1. the veracity of the data,
    2. the change in base cost data,
    3. the effect of proxy changes on the trending, and
    4. the consistency of CMS's methodology

  Before CMS updates the Labor Related Share to FFY 2002 data, it should address why it believes these fluctuations occurred and determine that it was not caused by changes in base data or methodologies.

- It appears that CMS has changed the labor related share without appropriately considering the budget neutrality adjustment for changes in the standardized amounts. Since those facilities with a wage index of less than 1.00 have already been assigned a labor related share of 62%, the reduction to the labor related share will result in a savings to the Medicare trust fund unless this savings is offset by an adjustment to the standardized rates.

Hospital Quality Data:

The ability of hospitals and their vendors to comply with the requirements for timely and accurate data submission is challenged by miscommunication, technical ambiguities, and other issues. Therefore, we believe that the final FY '06 inpatient PPS regulations should establish a clear documentation and communications process for this purpose. Further, we believe hospitals should not be penalized when technical issues specific to CMS or Quality Improvement Organizations (QIOs) hinder their ability to meet specific data requirements.

- An explicit, step-by-step process for data submission should be established—including exact specifications, all edits or audits to be applied, and other related information. Hospitals and vendors must be privy to such parameters to ensure timely data submission. Further, CMS should communicate any changes to submission file requirements no less than 120 days prior to the effective/implementation date. No changes should be permitted once a submission quarter has begun, as this puts process integrity at risk.

- For greater reporting accuracy, we believe that a test process for validating data file submissions and measuring calculations should be established. Hospitals and submission agents should be provided with a test file in the appropriate format for internal verification *prior* to testing a submission. The process should permit submission of test file(s) to verify file formats, accuracy of data calculations, and other audit criteria related to data submission. An appropriate test process should be permitted each time changes in data submission or measure specifications are prescribed.

- In the proposed rule, there is no mention of a minimum sample size for hospitals that elect to sample. Consequently, if hospitals that do *not* sample elect to submit all of their qualifying cases for a given study (i.e., 425 pneumonia cases for a given quarter) and three get "rejected," will they still meet the data requirements—or, must such hospitals correct the case errors so that *every* one gets into the warehouse? Under our reading of the proposed rule, it appears that they do not—so long as such hospitals have met the minimum number of cases required by the "aligned" JCAHO/CMS sampling requirements, however they are established.

- An explicit, step-by-step validation process should be established—including clear definitions, all applicable skip logic, all edits or audits to be applied, and other related information. Hospitals must know exactly *what* is being validated so they may adhere to the specifications during the data collection process. Under the current process, by the time hospitals receive feedback on one quarter's validation, they have already moved onto the next quarter's data collection and can not make changes quickly enough to impact the next quarter. If the validation specs and requirements were clear and well- documented, hospitals could be proactive. Any changes must be communicated clearly and within a timeframe sufficient for hospitals to react and changes their attendant processes. We propose that any modifications to the technical processes be published 120 days prior to the effective/implementation date.

- We believe that the validation process should incorporate *only* data associated with the ten specified measures. Under the current system, a hospital that submits multiple data sets may earn an *overall* quality score of 80 percent; however, if errors occur more frequently in the subset required for the annual payment update, the quality of such data may be considerably *lower*. In this way, payments risk being based on inconsistent calculations and inaccurate data.

- Further, we believe that hospitals should be notified of any validation rule changes at least 120 days prior to the hospital data abstraction period. The validation rules applied by CMS as of June 6, 2005 are, in fact, retroactive to the July—September 2004 data. CMS validated the three test LDL measures for the AMI clinical focus group. Consequently, hospitals are receiving mismatches for not collecting this optional data. The validation documentation for the July 1, 2004 discharges is dated April 29, 2005. Since the data was submitted at the end of January, hospitals have not had sufficient time to make the appropriate change.

- Under the proposed rule, CMS only allows ten days for a hospital to appeal its validation; however, the agency fails to specify whether the reference is to "business" or "calendar" days. We believe that *neither* case offers sufficient time for hospitals to respond. Therefore, we propose allowing hospitals 30 calendar days to appeal their validation findings.

- Many hospitals report having received inconsistent communications relating to the "data reporting for annual updates" provision of the Medicare drug law (MMA). We believe that all communications and directives regarding this initiative should be centralized and disseminated to all stakeholders (hospitals, vendors, and QIOs) simultaneously. Such a strategy would simplify and standardize message generation. It would also eliminate the confusing and often contradictory communications typical of the current process, which requires state QIOs to interpret a given communication before forwarding it to hospitals.

We appreciate the opportunity to comment on CMS proposed regulations for FY 2006, and hope that you will consider our comments to adjust the final regulations.

Sincerely,

Curt Zimmer
AVP/Controller

cc: Jim Aldrich, AH Director Budget & Reimbursement

WALZ
439 HART
TREITEL
Hefler
Hartstein

Submitter : Mr. Alan Broude **Date:** 06/24/2005

Organization : Jewish Hospital Healthcare Services

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-696-Attach-1.DOC

CMS-1500-P-696-Attach-2.PDF

TRANSFERS
NT
PYMT RTS/OUTLIER

Attachment 1 to #696

June 22, 2005

Mark McClellan, M. D., Ph. D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P. O. Box 80111
Baltimore, MD 21244-1850

Dear Dr. McClellan:

On behalf of Jewish Hospital Healthcare Services (JHHS) we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for the federal fiscal year 2006. The following are our comments:

I. Post-Acute Care Transfer Policy

JHHS is concerned about the continued expansion of the post-acute transfer policy. The proposed new policy expanding affected DRG's from 30 to 223 penalizes hospitals that ensure that Medicare patients receive treatment in the most appropriate setting. Expanding the policy to almost half of all DRG's undercuts the fundamental principle of PPS, which is that some cases will cost more than the DRG payment, some will cost less, but on average, the overall payments should be adequate. **We urge CMS to abandon this proposal.**

II. CHARITE Artificial Disk

We support and recommend a new DRG for this new technology. This procedure clearly does not fit in the Back and Neck Procedures (DRG's 499 & 500) due to the cost of this new technology. The development of a new DRG would ensure fair and equitable payment from Medicare and many other payers that pay in accordance with the Medicare DRG system.

III. Outlier Payment Threshold

We oppose the proposed increase in the outlier payment threshold from $25,800 to $26,675. Annually the outlier threshold is presumably set at a level that will result in total outlier payments of between 5% and 6% of actual total DRG payments. However, CMS estimates that in F FY2005 o utlier p ayments w ill represent o nly 4.4% o f t otal DRG p ayments. In FFY2004 CMS estimates that only 3.5% of total payments were outlier payments. This has

happened as CMS has increased the outlier threshold in 2004 and 2005. We believe the FFY 2006 outlier threshold should be lowered to ensure proper outlier payments to Hospital's.

We appreciate your consideration of these comments.

If you have any questions, please do not hesitate to contact me at (502) 587-4755.

Sincerely,

Alan L. Broude
Senior Vice President and
Chief Financial Officer

cc: D. Gregory Dorris, Vice President Finance/Revenue Cycle

Jewish Hospital
HealthCare Services

100

June 22, 2005

Mark McClellan, M. D., Ph. D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P. O. Box 80111
Baltimore, MD 21244-1850

Dear Dr. McClellan:

On behalf of Jewish Hospital Healthcare Services (JHHS) we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for the federal fiscal year 2006. The following are our comments:

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JHHS is concerned about the continued expansion of the post-acute transfer policy. The proposed new policy expanding affected DRG's from 30 to 223 penalizes hospitals that ensure that Medicare patients receive treatment in the most appropriate setting. Expanding the policy to almost half of all DRG's undercuts the fundamental principle of PPS, which is that some cases will cost more than the DRG payment, some will cost less, but on average, the overall payments should be adequate. **We urge CMS to abandon this proposal.**

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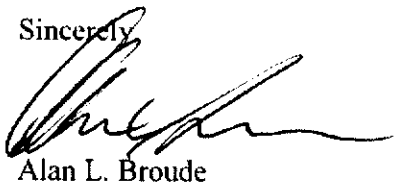
200 Abraham Flexner Way
Louisville, Kentucky 40202-1886
(502) 587-4011
(502) 587-4919 fax
www.jewishhospital.org

We appreciate your consideration of these comments.

If you have any questions, please do not hesitate to contact me at (502) 587-4755.

Sincerely,



Alan L. Broude
Senior Vice President and
Chief Financial Officer

cc: D. Gregory Dorris, Vice President Finance/Revenue Cycle

440

BODDEN
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LEFKOWITZ
RUIZ
COLLINS
MOREY
SMITH
HUDSON
ROMANO
M. Hammel

Submitter : Ms. Melissa Dehoff

Organization : The Hospital & Healthsystem Assoc. of Pa

Category : Health Care Provider/Association

Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-695-Attach-1.PDF

@ DATA
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LABOR S/N
MB/EX. HOSP
PYMT RTS/OUTLIER
TRANSFERS
GME/IRP
CAH/RELOC
CAH/LUGAR
LTC/DRG
SPH

ATTACHMENT TO # 695

HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

June 23, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500P
P.O. Box 8011
Baltimore, MD 21244-1850

Ref: CMS-1500-P—Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2006 Rates; (70 *Federal Register* 23306), May 4, 2005.

Dear Dr. McClellan:

On behalf of The Hospital & Healthsystem Association of Pennsylvania (HAP), which represents approximately 250 member institutions, including 125 stand-alone hospitals and another 120 hospitals that comprise 32 health systems across the state, we appreciate this opportunity to comment on the proposed rule "Medicare Program: Proposed Changes to the Inpatient Prospective Payment System and Fiscal Year 2006 Rates." Our hospitals and health systems throughout the state of Pennsylvania continue to be under extreme financial pressure. In order to ensure continued access to high quality health care for Medicare beneficiaries, adequate hospital payments under the Medicare Prospective Payment System is critical. Our comments focus on: CMS' proposed changes to the inpatient payment system, including those related to the wage index, outlier threshold, transfer policy, market basket, critical access hospitals, hospital quality data with regard to the validation process, and labor share revisions.

Hospital Quality Data

While audits and validation are necessary processes to ensure the data reported is accurate, HAP opposes CMS' attempt to link this validation process with the hospital update factor. The hospitals' experience with this validation process thus far shows the process to be unreliable.

HAP would also like to recommend that hospitals be notified by CMS of any validation rule changes **prior** to the hospital data abstraction period.

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Harrisburg, PA 17105-8600
717.564.9200 Phone
717.561.5334 Fax
haponline.org

With regard to the validation process, CMS should consider and focus more on whether appropriate care was provided, rather than medical record documentation as the current process is directed toward. Ensuring patients receive the proper care at the proper time should be incorporated into the validation process.

The hospital community should not suffer a payment reduction due to technical problems with the data submission and validation process. This fact should be taken into consideration.

Hospital Market Basket

HAP questions the accuracy of the FFY 2006 market basket projection. The projected market basket increase provides an estimate of cost increases; however, these increases are not reconciled to the actual increases for the proxies that are used. Some years the results of the projection were higher than the actual; while in other years it is lower. Over the life of the PPS, the differences have balanced out and the cumulative error has been small. However, in recent years the projection has been lower than the actual increase on a consistent basis. The actual increase in FFY 2004 was 3.8 percent compared to a market basket increase of 3.4 percent. In the FFY 2006 proposed rule, CMS reports that the FFY 2005 market basket increase is now estimated to be 4.1 percent compared to the estimated 3.3 percent increase that was projected for use in the update factor. As a result of this, HAP is very concerned that the methods being used by CMS to project the market basket are flawed and do not provide reliable results. Given a 4.1 percent cost increase for FFY 2005, the projected increase of 3.2 percent for FFY 2006 does not seem consistent with evidence that inflation is increasing in the general economy.

Labor-Related Share

CMS is proposing to decrease the labor-related share of the PPS rate. HAP opposes this decrease due to pending finalization of the methodology for calculating the labor-related share. In the FFY 2003 inpatient proposed rule, CMS examined the methodology used to determine the labor-related share. CMS' calculation of the labor-related share in FFY 2003 resulted in an increase from 71.06 percent to 72.495 percent. However, CMS did not implement the increase due to continued research being conducted to determine whether a different methodology for determining the labor-related share should be adopted. In the FFY 2006 proposed rule, CMS again discusses continuing research on alternative methodologies for calculating the labor-related share. The proposed rule indicates that CMS has not yet produced enough sound evidence to propose a change. It is evident that CMS is still researching this issue. Based on this information, it is unfair to implement a labor-related share increase pending an analysis of the methodology and then use a labor-share decrease while the analysis in incomplete. HAP recommends keeping the labor-related share at 71 percent until a new methodology is developed.

Excluded Hospital Market Basket

In this rule, CMS proposes to use the proposed FY 2002 IPPS operating market basket percentage increase to update the target amounts for children's and cancer hospitals. HAP opposes this decision and feels changes should not be made to the market basket for children's and cancer hospitals until after a decision is made on the development of a separate market basket for other exempt facilities, such as IRFs, IPFs, and LTCHs. The data that is used for the children's and cancer hospitals are included in the current exempt hospital market basket and the updates should be continue to be based on that. A proposal such as this should include a more detailed analysis of the cost structures of these hospitals.

Operating Payment Rates

The proposed fixed-loss cost outlier threshold for FY 2006 represents an increase of 3.4 percent from FFY 2005 ($25,800 to $26,675). While this threshold is not a substantial increase, HAP is concerned that the threshold is too high. The increase cited will make it more difficult for hospitals to qualify for outlier payments and will put them at risk for treating those Medicare patients with unusually high costs. Given the shortfall in FFY 2004 and FFY 2005 compared to the 5.1 percent target for outlier payments, HAP is concerned that the proposed 3.4 percent threshold increase will result in another year of underpayments.

Post-acute Care Transfers

HAP **strongly** opposes the expansion of the post-acute transfer policy. In this proposed rule, CMS makes substantial revisions to the DRG selection criteria with little evidence or justification. Such an extensive expansion of the post-acute transfer policy acts as an across-the-board reduction in Medicare payments and is not in the best interest of patients. This policy undermines clinical decision-making and penalizes hospitals for providing efficient and effective care in the setting that is most appropriate for the patient. Hospitals should not be financially penalized for making sound clinical judgments regarding the locale to best meet a patient's clinical needs. CMS should not be cutting payments with shorter stays without increasing payments to longer stays. Has CMS considered those patients that do not have access to post-acute care? How will this impact other venues, such as home health, and will this really save money? The proposed expansion to 231 DRGs will reduce Medicare reimbursement to hospitals in Pennsylvania by a very significant amount: between $50 and $60 million or approximately 1.1 percent of total inpatient Medicare revenues. Expansion of the transfer policy undercuts the basic principles and objectives of the Medicare prospective payment system, is based on assumption of "gaming" that is not validated by the data, and unnecessarily adds complexity and opportunity for error to an already complex system.

Initial Residency Period for DME Payment

HAP supports CMS' proposed change to the policy for the initial residency period. This change would allow hospitals to be paid an entire full-time equivalent (FTE) rather than half of an FTE for such residents until they are board eligible.

Critical Access Hospitals

HAP strongly opposes the proposed restrictions related to critical access hospital (CAH) replacement or relocation in the rule that are based on arbitrary deadlines. HAP believes the proposed 75 percent threshold to be sufficient to assure that replacement or relocation of a CAH continues to meet the intent of the original "necessary provider" designation.

The proposed restrictions would result in hospitals designated as CAHs through the necessary provider criteria to be bound to their current location, even if the age and inefficiencies of the facility make building a new facility the better option for patients and from a cost standpoint. Many CAHs are in 40-50 year old buildings with antiquated floor plans, construction, and utilities. Newer facility designs support enhanced patient safety and quality as well as staffing efficiencies, a critical consideration in light of the health care personnel shortages these facilities face.

Forcing renovation of these aging physical plants when an assessment by experts indicates replacement is the better option is inappropriate. One of our Pennsylvania CAHs, against the advice of experts but in an attempt to save money, had major renovations done to its aging physical plant rather than building a new facility. The result: a hospital that continues to be very inefficient in design leading to increased staffing costs and patient safety concerns, ongoing damage to the renovation due to problems created by the old infrastructure, and an attractive facility that is draining the community of its resources and hospital. The CAH is now contemplating building a new facility several miles from its current location, but in the heart of its small community, which would improve access and help revitalize a struggling downtown. The proposed rule would prohibit this, despite the fact the hospital would continue to serve, and in fact, better serve, its target population in this rural community.

Lugar Reclassification

Congress intended for Lugar reclassifications to benefit hospitals in eligible counties, and most affected hospitals do, in fact, benefit from the reclassification. However, some hospitals are disadvantaged by the reclassification and the "urban" status that accompanies it. Those disadvantaged by the classification include Rural Referral Centers, Sole Community Hospitals, Medicare Dependent Hospitals, and Critical Access Hospitals. To achieve one of these specialty designations, the hospital not only has to be rural, but also has to meet specific criteria substantiating the hospital's essentialness to access. It is ironic that the very hospitals congress sought to help and preserve through

these specialty designations are the ones who will be harmed, not helped, by the Lugar reclassifications.

HAP urges CMS to provide a limited window of opportunity for hospitals disadvantaged by the Lugar reclassification to waive or reject the reclassification, just as it permits hospitals to reject other geographic reclassification and wage index adjustments during a defined period. Congressional intent certainly supports providing an opportunity for disadvantaged hospitals to reject Lugar reclassification.

LTC-DRGs

CMS cites proposed methodology for re-weighting that would remove statistical outliers and short-stay cases from the re-weighting calculation. HAP is concerned that this proposed methodology would inappropriately remove the selected categories of LTCH patients from the calculation. CMS is essentially diminishing the principle of averaging, which is a fundamental feature of the prospective payment system.

Specialty Hospitals

HAP supports CMS' decision to delay processing of any additional requests for Medicare provider numbers from limited-service hospitals until the completion of a review and revision of the procedures for evaluating such requests. HAP commends CMS for recognizing this issue as a problem.

HAP appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about our comments, please contact Melissa Dehoff, director, health care continuum finance policy, at (717) 561-5318, or by email at mdehoff@haponline.org.

Sincerely,

Carolyn F. Scanlan

CAROLYN F. SCANLAN
President and Chief Executive Officer

CFS/dd

441 WALZ HART MILLER HEFTER HARTSTEIN Kenly

CMS-1500-P-693

Submitter : Ms. Gilda Ecroyd **Date:** 06/24/2005

Organization : NYU Hospitals Center

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1500-P-693-Attach-1.DOC

TRANSFERS WI/ ~~SN~~ GEN CB SAS

Attachment to #693

June 23, 2005

The Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
Room 445-6
Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1500-P, Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year (FY) 2006 Rates; Proposed Rule

Dear Mr. McClellan,

On behalf of NYU Hospitals Center, I appreciate this opportunity to submit comments on the proposed rule on the Medicare Hospital Inpatient Prospective Payment Systems (IPPS) for FY 2006, as published in the May 4, 2005, *Federal Register.*

Post Acute Transfer Policy

NYU Hospitals Center is most concerned about the proposed policies of extending DRGs to 231 in the post-acute transfer policy. This regulation is not in the best interest of our patients. The financial impact on NYU Hospitals would be $3.1 million. Such a tremendous cut in payment is inappropriate and destructive to the goal of achieving high quality health care for our patients.

Patients must be placed in the most appropriate level of care, given their individual health factors and complications. We want to be sure that each patient receives the care he or she needs to reach the highest level of quality care of life and to function best in our society. The federal government and insurers should not be second guessing our well-educated and highly trained physicians on the appropriate level of care for their patients. The NYU Hospitals strongly opposes the post-acute care transfer policy in general and we are against the expansion of this policy in the proposed FY 2006 regulation.

Hospital Wage Index

The NYU Hospitals opposes the use of "core-based statistical areas" (CBSA's) in place of MSAs that result in higher payments to certain hospitals, at the expense of others. I urge you to hold harmless those hospitals that would suffer significant losses as a result of this revision.

Thank you for your consideration of these comments.

Sincerely,

Gilda Ventresca-Ecroyd

CMS-1500-P-692

442

WALZ
HART
TREITEL
HEFTER
HARTSTEIN

Submitter : Mr. Walter Wyatt

Date: 06/24/2005

Organization : Albert Einstein Healthcare Network

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-692-Attach-1.DOC

TRANSFERS
PYMT RTS/OUTLIERS

Attachment to #692

Albert Einstein Healthcare Network

Einstein

Jefferson Health System

June 24, 2005

Mark McClellan, M.D., Ph.D.

Administrator

Centers for Medicare & Medicaid Services
Attention: CMS-1500-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. McClellan:

The Albert Einstein Medical Center (AEMC) welcomes the opportunity to comment on the Center's for Medicare & Medicaid Services' (CMS) proposed rule entitled *"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates."*

The Albert Einstein Medical Center is a teaching hospital offering a full range of advanced health services to one of most diverse, urban underserved communities in the Philadelphia area. The medical center includes a Level I Regional Resource Trauma Center and a Level III Neonatal Intensive Care Unit. Our Network cares for over 32,000 inpatients and over 450,000 outpatients annually. Most of these patients are covered either by Medicare or Medicaid, and many qualify under both of the federally sponsored Health Insurance Programs. Those patients who are eligible for Medicare or Medicaid make up approximately 80% of the total patients receiving care at AEMC.

In order to ensure the continued access to high quality healthcare for Medicare beneficiaries in the Philadelphia region, it is critical that we receive adequate payments under the Medicare Prospective Payment System. Our comments focus on the proposed changes to the post-acute transfer policy and the outlier threshold.

Post-Acute Transfers

AEMC strongly opposes any expansion of the post-acute transfer policy. In this proposed rule, CMS makes substantial revisions to the DRG selection criteria with little or no evidence that support such a change. CMS is proposing that a DRG with at least 2,000 discharges to post-acute care will qualify as one of the DRG's falling under the new post-acute transfer policy. It is clear that CMS has backed into this criterion by including all DRG's with a geometric LOS greater than 2 days. Establishing a threshold of 2,000 discharges does not comport with the statutory directive that CMS focus on those DRG's that have a high volume of discharges to post-acute care and a disproportionate use of post-discharge services.

If implemented, this policy would penalize hospitals that ensure that Medicare patients receive care in the most appropriate setting. This policy would also be inconsistent with the fundamental principal of the Prospective Payment System, which is that some cases will cost more than the DRG payment, while others will cost less, but on average, the overall payments should be adequate.

Outlier Payment Threshold

AEMC opposes any increase to the current outlier threshold amount. CMS' continued inappropriate use of charge inflation data to determine the projected increases in per case costs has resulted in outlier underpayments over the last two Federal Fiscal Years (FFY). In FFY 2005 outlier payments are estimated to be only 4.4 percent of actual DRG payments. In FFY 2004 outlier payments represented only 3.5 percent of DRG payments. In both Federal Fiscal Years the actual payment percentages were less than the 5.1 percent reduction to the standardized amount. We suggest that CMS use both charge and cost data in determining the outlier threshold. Analysis conducted by the Association of American Medical Colleges, in conjunction with the American Hospital Association and the Federation and American Hospitals, that incorporate both cost and charge inflation, actually reflect that the outlier threshold should be decreased to $24,050 in FFY 2006.

We appreciate the opportunity to submit these comments on the proposed rule. If you should have any questions about our comments I can be reached at 215-456-7315.

Sincerely,

Walter G. Wyatt Jr.
Director, Budget & Reimbursement
Albert Einstein Healthcare Network

443

Submitter : Mr. Alan Morgan

Date: 06/24/2005

Organization : National Rural Health Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachement

CMS-1500-P-727-Attach-1.DOC

CMS-1500-P-727-Attach-2.DOC

CMS-1500-P-727-Attach-3.DOC

CAH Reloc
W1/OM
TRANSfers
SCH/MDH
DSH
Geo Reclas
CAH LugAR
IMPACT

Hefler
Hartstein
Collins
Morey
Smith
Miller
Walz
Hart
Navarro
Renly
T. Jones
Kraemer

Attachment 1 to #727

Headquarters
One West Armour Boulevard, Suite 203
Kansas City, Missouri 64111-2087
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FAX: [816] 756.3144

Government Affairs Office
1600 Prince Street, Suite 100
Alexandria, Virginia 22314-2836
Telephone: [703] 519.7910
FAX: [703] 519.3865

NATIONAL RURAL HEALTH ASSOCIATION

June 23, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850.

Reference: CMS-1500-P

Dear Administrator McClellan:

The National Rural Health Association (NRHA) appreciates the opportunity to comment on the proposed rule implementing changes to the hospital inpatient prospective payment systems and fiscal year 2006 rates published in the May 2005 **Federal Register**. We appreciate your ongoing commitment to rural health care, and the NRHA looks forward to working with you in our mutual goals of improving access and quality of health care for all rural Americans.

The NRHA is a national nonprofit membership organization that provides leadership on rural health issues. The association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

Of particular concern to NRHA is the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding replacement or relocation of a Critical Assess Hospital (CAH) that have been designated as a Necessary Provider (NP).

Or comments are as follows:

CAH Replacement Facilities

1.) **We strongly oppose all deadlines for actions related to Critical Access Hospital (CAH) replacement or relocation in the Inpatient Prospective Payment System (IPPS) final rule.**

2.) **The proposed "75% threshold" is appropriate and sufficient to assure that a replacement or relocation CAH facility continues to meet the intent of its original Necessary Provider designation,** i.e. that the "CAH serves at least 75 percent of the same service area that it served prior to its relocation, provides at least 75 percent of the same services that it provided prior to the relocation, and is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees."

Our basis for this position is as follows:

1. The Proposed Regulation transfers to the Centers for Medicare and Medicaid Services (CMS) control over the basic structure of local rural health care, a loss of local control never before seen, and if allowed to stand, a precedent that threatens all hospitals and all communities.

2. It was clearly not the intent of Congress in the Medicare Modernization Act that a Critical Access Hospital (CAH) designated as a Necessary Provider be perpetually prohibited from replacing or relocating their facility, facilities that are often 40 to 50 years old.

3. Many rural hospitals are located on a small campus in the middle of residential neighborhoods with relocation being the most appropriate, and sometimes only, alternative since there is no room to expand on the existing site.

4. The proposed rule will force CAHs to allocate funds to renovate structures that no longer meet either the needs or the demands of modern health care. As inefficiencies are realized, CMS will be forced to provide more money through cost-based payment to maintain an aging and declining healthcare infrastructure in rural America. Ironically, the CMS proposal to ban a local community's ability to rebuild on an adjacent or nearby location will cost Medicare more over time, not less. The higher labor costs of operating in a retrofitted building more than offset the slightly higher initial cost of rebuilding. The proposal displays a short sighted thinking process by the rule makers and a dramatic misunderstanding of the health care setting in rural areas.

5. Many rural hospitals are in 40 to 50 year buildings with antiquated floor plans, construction and utilities. Newer facility designs promote patient safety and quality of care that would be, as a practical matter, prohibited by the proposed rule. Forcing hospitals to continue in facilities after they become outdated is an inappropriate and avoidable risk for rural communities.

6. A ban on major construction projects developed after December 8, 2003 is an over reaction against a potential problem that can be appropriately managed by the portion of CMS's proposed rule that would require assurance that, after the construction, the CAH will be servicing the same community and will be operating essentially the same services with essentially the same staff.

7. The CMS ban is based on the misguided belief, not tested in law and a break with CMS's past policy that the relocation of a CAH can be treated differently than the relocation of any other

hospital. There is no basis in law that the relocation within a community of a CAH with Necessary Provider status constitutes a cessation of business and loss of its provider agreement and number.

8. A CAH's Necessary Provider designation is associated with its current Medicare provider agreement that remains intact unless the CAH fundamentally changes its business (e.g., ceases its current operations) or is terminated by Medicare. It is a longstanding policy that the provider agreement describes the legal entity and services provided—not the physical structure or location.

On June 6, 2005, the NRHA facilitated a conference call between a sample of CAH hospital CEOs, to provide specific examples of the impact this proposed regulation is having on their facilities. See **Attachment A** for a detailed account of their examples.

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CMS proposes to continue adjusting 10% of the wage index by an occupational mix adjustment. CMS noted last year some confusion and inconsistency with the data accumulated in the first occupational mix survey. We recognize this survey process was new to providers, intermediaries and CMS, and agree that there is likely a great deal of inconsistency in the way different hospitals completed the survey.

We encourage CMS to revisit this process immediately and gather new data within the next year, rather than waiting two more years before obtaining such data. At the same time, more detailed instructions should be issued to clarify the types of data reported, and how occupational data should be recorded on the survey form. CMS notes that a **Federal Register** notice will be published outlining changes to the survey process, and we look forward to reviewing this notice.

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PACT policy, the usage of post discharge services would have to be outside the norm. CMS previously published criteria that somewhat accomplished this goal, by requiring 14,000 PACT cases for a DRG to be included under the policy. By excluding the 220 DRGs with lengths of stay of less than 3.0 days, CMS effectively proposes to include every other possible DRG under the policy that had 100 or more transfer cases.

To demonstrate that it has met the intent of the law, CMS should publish a complete list of all DRGs showing how many total cases each DRG had and how many of those cases included usage of post discharge services. The usage rate should also be computed for each DRG, as well as the overall average usage rate. We believe a usage rate at least one standard deviation above this average should be set as a minimum before a DRG is made subject to the PACT policy. We do not believe any change is needed in the current PACT policy. However, if CMS does propose such a change, we believe the clear intent of the law is to limit the PACT policy to DRGs with a disproportionate use of post discharge services, something CMS does not demonstrate with its proposal.

Further, we do not believe that CMS is required to implement changes to the PACT policy as actual reductions in Medicare spending. We request CMS make the postacute transfer policy a budget neutral policy, such that any reductions in Medicare spending through revisions to this policy be paid to providers through an increase in the PPS update factor.

Sole Community Hospitals and Medicare Dependent Hospitals

CMS proposes to modify the budget neutrality adjustment applied to hospital-specific payment rates for SCHs and MDHs to no longer consider changes in the wage index when applying the budget neutrality adjustment to hospital-specific payment rates. However, CMS fails to quantify the impact of this proposal. We request more detailed information regarding the impact of this change on fiscal 2006 payments, as well as the impact if this change was imposed retroactively.

DSH Adjustment Data

We appreciate the efforts CMS is making to comply with Section 951 of the Medicare Modernization Act, which required that CMS make certain DSH adjustment data available by December 8, 2004. CMS notes that a future **Federal Register** notice will publish more details on this issue. Due to the significance of this issue and the time that has already elapsed since December 8, 2004, we request that CMS expedite its efforts to make such data available.

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by going to the website identified in the proposed regulations. We request further clarification concerning these codes or a more detailed website reference to link to the codes.

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As a result of the most recent labor market changes, some counties that were previously considered rural were redisignated as urban. Per the MMA, a rural county that is adjacent to one or more urban counties is considered to be located in the urban MSA to which the greatest number of workers in the county commutes, if certain conditions are met. These are known as "Lugar Counties." Thus, some CAHs are now located in Lugar counties and are unable to meet the rural location requirement, even through they were in full compliance at the time they were designated as critical access.

In response, CMS proposes that CAHs in counties that were designated Lugar counties effective October 1, 2004 because of the new labor market definitions will be allowed to maintain their CAH status until September 30, 2006. NRHA supports this continued transition to allow for the opportunity for these facilities to reclassify.

Budget neutrality and RCH demonstration

The NRHA supports the decision of CMS to achieve budget neutrality for the rural community hospital demonstration by adjusting the total of all PPS payments. This is a fair and reasonable means of balancing the modest cost of this demonstration.

Evaluation of the RCH demonstration

The NRHA looks forward to seeing the evaluation/assessment of the RCH program. We offer our assistance to the contractor awarded this task. We are concerned that all possible benefits and costs be considered, which we believe will require input from experts knowledgeable of special rural circumstances.

Registered Nursing: page 23375

The NRHA is deeply disturbed by the unsupported statement that hospitals are accounting for the shortage of physicians by hiring more registered nurses. We know of no instance of this occurring. The statement implies a practice of downgrading care, especially since it uses "registered nurses," not even nurse practitioners (who deliver primary care). We ask that this statement be stricken from the final rule.

Conclusion:

We believe at this time, it is important to address for the public record, a much larger issue concerning CMS's internal misunderstanding of the CAH program in general.

Through CMS actions regarding the CAH program over the past four years, it appears that the agency internally perceives the growth of the CAH program incorrectly. **This growth of the CAH program was specifically intended by Congress. Furthermore, the growth of the program is limited by the number of rural hospitals that reasonable have twenty-five or fewer beds.** Every reasonable estimate puts this potential universe at less than 1500 hospitals nation-wide. More that 1100 hospitals have already converted to CAH status., leaving fewer than 400 hospitals even potentially eligible for this designation. Attention should be paid to the total cost of the program (approximately $3B annually) and the additional cost as compared with all these CAHs being PPS hospitals (less than $800M according to MedPAC figures) compared with the total hospital budget this year for CMS of better than $239B.

The NRHA appreciates the opportunity to submit these comments on the proposed rule. Please do not hesitate to contact Alan Morgan, Interim Executive Director at 703-519-7910 if you have any questions about these comments.

Sincerely,

Hilda R. Heady

Hilda Heady
President

Attachment 2 to #727

June 23, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850.

Reference: CMS-1500-P

Dear Administrator McClellan:

The National Rural Health Association (NRHA) appreciates the opportunity to comment on the proposed rule implementing changes to the hospital inpatient prospective payment systems and fiscal year 2006 rates published in the *May 2005* **Federal Register**. We appreciate your ongoing commitment to rural health care, and the NRHA looks forward to working with you in our mutual goals of improving access and quality of health care for all rural Americans.

The NRHA is a national nonprofit membership organization that provides leadership on rural health issues. The association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

Of particular concern to NRHA is the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding replacement or relocation of a Critical Assess Hospital (CAH) that have been designated as a Necessary Provider (NP).

Or comments are as follows:

CAH Replacement Facilities

1.) **We strongly oppose all deadlines for actions related to Critical Access Hospital (CAH) replacement or relocation in the Inpatient Prospective Payment System (IPPS) final rule.**

2.) **The proposed "75% threshold" is appropriate and sufficient to assure that a**

replacement or relocation CAH facility continues to meet the intent of its original Necessary Provider designation, i.e. that the "CAH serves at least 75 percent of the same service area that it served prior to its relocation, provides at least 75 percent of the same services that it provided prior to the relocation, and is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees."

Our basis for this position is as follows:

1. The Proposed Regulation transfers to the Centers for Medicare and Medicaid Services (CMS) control over the basic structure of local rural health care, a loss of local control never before seen, and if allowed to stand, a precedent that threatens all hospitals and all communities.

2. It was clearly not the intent of Congress in the Medicare Modernization Act that a Critical Access Hospital (CAH) designated as a Necessary Provider be perpetually prohibited from replacing or relocating their facility, facilities that are often 40 to 50 years old.

3. Many rural hospitals are located on a small campus in the middle of residential neighborhoods with relocation being the most appropriate, and sometimes only, alternative since there is no room to expand on the existing site.

4. The proposed rule will force CAHs to allocate funds to renovate structures that no longer meet either the needs or the demands of modern health care. As inefficiencies are realized, CMS will be forced to provide more money through cost-based payment to maintain an aging and declining healthcare infrastructure in rural America. Ironically, the CMS proposal to ban a local community's ability to rebuild on an adjacent or nearby location will cost Medicare more over time, not less. The higher labor costs of operating in a retrofitted building more than offset the slightly higher initial cost of rebuilding. The proposal displays a short sighted thinking process by the rule makers and a dramatic misunderstanding of the health care setting in rural areas.

5. Many rural hospitals are in 40 to 50 year buildings with antiquated floor plans, construction and utilities. Newer facility designs promote patient safety and quality of care that would be, as a practical matter, prohibited by the proposed rule. Forcing hospitals to continue in facilities after they become outdated is an inappropriate and avoidable risk for rural communities.

6. A ban on major construction projects developed after December 8, 2003 is an over reaction against a potential problem that can be appropriately managed by the portion of CMS's proposed rule that would require assurance that, after the construction, the CAH will be servicing the same community and will be operating essentially the same services with essentially the same staff.

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Sincerely,

Hilda Heady
President

Attachment 3 to #727

NRHA CMS Conference Call
June 6, 2006
CAH Replacement Facility Issue

Opening Comments from Alan Morgan, NRHA Interim Executive Director:

First I want to thank the Centers for Medicare and Medicaid Services for participating in this call with the NRHA. I greatly appreciate CMS's willingness to work with rural providers to ensure that we maintain access to quality health care services for all Americans.

We have scheduled a half hour call today, for the purpose of allowing just a small sample of Critical Access Hospitals to have direct interaction with key CMS officials regarding the recently released, and now open for public comment, regulation regarding future replacement facilities for CAHs. I have been hearing quite a bit from our members on this particular proposed regulation, and in specific concern about the unintended consequences of this reg. I hope this call helps shed some additional light for CMS on the concerns that I have been hearing, and also assists you in your development of a final regulation on this issue.

With that, we can proceed with allowing our CEOs to briefly state their situation regarding this proposed regulation, and then we should be able to permit a couple questions from CMS staff on the particular case, before moving on to the next CEO. We should have about 5 minutes total for each example, with five-ten minutes at the end for any last minute questions comments.

If that is agreeable with everyone, we can start with our first CEO.

Jeffrey Meyer, CEO, Osceola Medical Center, Osceola, WI :

Our facility was built in the 1940s, it is located right on a river bluff surrounded by a residential area and the downtown with no option for additional expansion to the current facility. We have seen growth in the community and in our patient volume. But as we are growing, we have no room to expand. We are now providing new services, we want to add more options for our community, but we just don't have the room to do that. We are running out of parking as well. The infrastructure is aging. We just need more space. We purchased property one mile from site in July 2004, but we are now forced to hold off until we see the final rule from CMS. We have done preliminary work, but we need a better picture of where CMS is headed before we move forward.

Joan Murray, CEO, St. James Parish Hospital, Lutcher, LA:

Our facility is 50 years old and we are faced with all the problems associated with this fact. We spend a great deal of money to keep the facility in working shape. We did a

facility master plan to determine if we should renovate or replace, and determined that the short term cost to renovate was not much less than the cost of building a new facility. We engaged a mortgage banker in 2003, and we made an application to HUD in 2003 for a loan. We determined that we would take a duel track and with apply for both a HUD and USDA loan. In October of 2003 we made a land agreement. We selected a project manager and an architecture firm, but we did not complete more than 80 percent of the preliminary work until May. We have received positive feedback from the USDA, but we have now learned that while HUD would love to fund the project and perceive us to be a good candidate for the funds, HUD will not move forward until they know what will happen with your new regulations. We have already spent $1 million on process. We are now on hold until the final regulation from CMS. The new site is only 300 yards from the existing facility.

Calvin Green, CEO, Franklin Foundation Hospital, Franklin, LA:

We are the only non-profit hospital in our service area. In our area, unemployment is at 10 percent. We face significant barriers to access to care. Our current facility is 50 years old. It was originally a 70 bed acute care facility with 90,000 square feet. In April, we down sized from 70 to 25 beds to be a critical access hospital. We operate on three floors with services scattered throughout. This results in great staff inefficiencies. Maintaining site quite a problem. We have tried to close down the parts of the building that are not being used but can't. Because of mildew problems, we must maintain the entire structure. The bulk of their design and development work for our new site has taken place over the past few months. New site is about 2 miles away from current site. We have completed the plan design and architectural drawing. We received $5 million from state of Louisiana. specifically for the construction of a new facility. The rest of the money is from USDA. We retained our project manager in the middle of 2003. We received funding from state in June, 2003. The project manager did the site analysis in Nov 2003, but land was not purchased until 2004. We are proceeding in the process. We have spent $1.3 million to date. We are now taking bids from construction companies, but we will not award a construction contract until we know the final rule from CMS.

In addition, two CEOs were not able to participate in the call but have submitted the following remarks:

Bill Bruce, CEO, St. Joseph's Community Health Services, Hillsboro, WI:

In the summer of 2004 our local hospital and foundation Boards received their annual reports that another successful year had just been completed. This included providing the only family practice service whose physicians live in our local area and serve the local population of about 18,000 people in this area of southwestern Wisconsin. It also included the ongoing presence of a local nursing home serving the elderly. However, the backbone of this success has, and continues to be our local (critical access) hospital. The continuation of this success will be at significant risk if the CMS proposal published in the May 4 Federal Register goes into effect.

Attachment 3 to #727

St. Joseph's Community Health Services, Inc. converted to "Critical Access" status in early 2000. The alternative at that time was likely closure of the hospital in the continued environment as a "PPS" hospital.

Since that time the hospital has been able to stand on its own financially and clinically. Doctors have been recruited where none existed. New technology has led to a virtual linkage with the University of Wisconsin Radiology academic faculty on a 24/7 basis. "Visiting Specialists" from the urban areas have started clinics to serve local needs.

As a result of these changes, local leadership has realized that we will not be able to meet state and federal regulations relating to the conditions of participation without significant renovation of the facility. In the fall of '04 architectural, engineering and construction management firms were retained to analyze the situation.

The report that came back was a surprise to all concerned.

When taking into account the need to provide contemporary ambulatory care and short term inpatient acute care the existing facility built in the 50's was inadequate from an efficiency, space and operational cost standpoint. It was pointed out that the state would not allow new construction in place of a man-made lake immediately behind the facility nor allows the closure of a highway in front of the facility. From a life cycle construction cost standpoint the hospital would be better off to build a new facility on a nearby site and vacate the existing site. Sites have been identified in the local area that are suitable but would require the facility to be relocated about 2-3 miles from the existing site.

However, with the proposed CMS rule this would not be possible. The rule will require that on site renovation be done at a cost higher than new construction and operated at a cost higher than a more efficient layout than currently exists. We project (if forced to renovate) the result will be added cost to our health care system; one that is already strained to keep up at a state and federal level.

It is clear that everyone must do their part. As for St. Joseph's Community Health Services, Inc. that is being responsible stewards of our precious health care resources. Federal rules need to be adjusted to let local common sense and cost effective solutions prevail. For our situation, that means that a new facility in the local area makes the most sense for all concerned, including CMS.

Although we can't individually solve the federal and state budget pressures due to the provision of Medicare and Medicaid services it clearly does not make any sense to add to the burden of our taxpayers with a rule that adds both up front and ongoing increases in operational expenses.

Tom Hudgins, Administrator/CEO, Pinckneyville Community Hospital, Pinckneyville, IL:

Pinckneyville Community Hospital and Marshall Browning Hospital, located 10 miles apart in Perry County, Illinois, are Necessary Provider CAH's presently discussing consolidation. Neither has the ability to expand to accommodate the areas needs on their respective sites. A single new facility on a new site would accomplish meeting the needs of the areas presently served. If the proposed rule stays as is, the consolidation discussions will cease and the two facilities will move forward independent of each other with their plans to provide for their future needs.

Attachment 3 to #727

444

Submitter : Mr. Dennis Mitchell **Date:** 06/24/2005

Organization : Stony Brook University Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-730-Attach-1.PDF

Transfers
Labor/S
Pymt Rt/outliers
Q DATa
W1/OM
MB/H
DRG/GeN

Hefler
Hartstein
Walz
Hart
Treitel
Seifert
Knight
Bodden
M. Hammel
Miller
Brooks
Fasan
Gruber
Kelly
Hue

ATTACHMENT TO #730

Smart Medicine
STONY BROOK
UNIVERSITY HOSPITAL
Expert Care

Finance

June 24, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Subject: Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule, *Federal Register* 70, no. 85 (May 4, 2005): 23306–23673. [CMS-1500-P]

Dear Dr. McClellan:

On behalf of [name of hospital], I appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule for the Federal fiscal year (FY) 2006 inpatient prospective payment system (PPS). [Give some background about hospital.]

Our principal recommendations this year are:

1. Post-acute care transfers. We strongly oppose CMS's proposal to expand the post-acute care transfer policy. We believe that the entire policy is wrong and that there is absolutely no justification for decreasing aggregate Medicare payments as a result.

2. Labor share. We believe that CMS should not update the cost category weights in the hospital market basket unless it also designates professional liability insurance as a labor-related cost.

3. Outliers. We are very disturbed that CMS has not been able to estimate the cost outlier threshold to a reasonable degree of accuracy, noting that the Agency estimates it did not spend 31% of the outlier pool in FY 2004.

4. Hospital quality data. We believe that the current flaws in the data validation process are so fundamental that CMS should not tie the full payment update to that process in FY 2006.

5. DRG reclassifications. We support CMS's proposals for DRG refinement and request that the agency also create new DRGs for a) ischemic stroke treatment with a reperfusion agent, which would only include strokes that were caused by clots and treated with tissue plasminogen activator, and b) cardiac defibrillator implant without cardiac catheterization, but with cardiac electrophysiologic stimulation and recording studies.

More detailed comments about these issues are provided below.

Post-acute Care Transfers

During the 1990s, the national average length of stay decreased by about 2% per year, coincident with the expansion of managed care. One of the mechanisms hospitals used to decrease length of stay was to discharge patients to post-acute care. CMS and the Medicare Payment Advisory Commission (MedPAC) became concerned that the Medicare program was being exploited because spending was increasing rapidly for post-acute care services, but hospital payments were not adjusting fast enough to sufficiently offset some of the post-acute care increase. This was because diagnosis-related group (DRG) weights are based on two-year-old data.

Therefore, through the Balanced Budget Act of 1997 (BBA), Congress directed CMS to begin reimbursing short-stay discharges to post-acute care in 10 DRGs as transfer cases. Transfer cases receive only partial DRG payment. In hindsight, this directive was too late because length of stay stabilized early in this decade. Therefore, the DRG weights based on two-year-old data are no longer imbalanced. Nonetheless, in FY 2004, CMS extended its post-acute care transfer (PACT) policy to 29 DRGs and now, for FY 2006, the Agency is proposing to fully implement the policy by extending it to 231 DRGs, which are virtually all the DRGs to which the policy could reasonably be applied.

We strongly opposed the FY 2004 expansion of the PACT policy and more strongly oppose it now because the patients to whom it applies cannot legitimately be construed as transfer cases. The cases to which the policy is now—and would be—applied are merely cases with a shorter-than-average length of stay. Therefore, reducing the payment for these cases should be recognized as a form of case-mix refinement and, if it were done, should be budget-neutral. There is absolutely no justification for CMS taking savings from this policy, whether it is expanded or not.

The question then becomes whether this form of case-mix refinement is desirable. We feel strongly that this policy is inappropriate because it characterizes a low length of stay as an indicator of a clinically inappropriate discharge, which conflicts with the more contemporary and more prevalent characterization of a low length of stay as an indicator of efficiency. In fact, length of stay is probably the most common measure of efficiency. We have worked very hard to reduce length of stay through better care coordination. Deeming a stay incomplete merely because the length of stay is shorter than the geometric mean minus one day is arbitrary and undermines our efforts. Furthermore, refining the DRGs to pay less for shorter-stay cases also undermines the incentive built into the case payment methodology, which is that hospitals would be rewarded for efficiency.

Hospital Wage Index: Occupational Mix Adjustment

CMS conducted its first occupational mix survey in a highly compressed time frame in early 2004 and did not have confidence in the validity of the results. For that reason, the agency implemented a 90%-10% blend of the unadjusted area wage index and the occupational mix-adjusted area wage index, respectively, in FY 2005. For the past year, hospitals have had the opportunity to correct any mistakes they may have made in their original submissions, so CMS should have greater confidence in the validity of the current occupational mix adjustments. Nonetheless, CMS has proposed to continue the blend in FY 2006 in the same proportion as the blend used in FY 2005. We do not believe that continuing the blend is appropriate and urge CMS to fully implement the occupational mix adjustments in FY 2006.

Hospital Market Basket

The sum of the labor-related hospital market basket cost category weights represents the portion of the standardized amount that is wage-adjusted. The current labor share is 71.1% and it is based on FY 1992 data. CMS would have updated the weights in FY 2003 based on FY 1997 data, but declined to do so because the update would have increased the labor share to 72.5%, which would have hurt rural and other low-wage hospitals. Now CMS is proposing to update the weights based on FY 2002 data, which would reduce the labor share to 69.7% and hurt high-wage urban hospitals. This change would not materially help rural and other low-wage hospitals because their labor share was fixed at 62% in the Medicare Modernization Act of 2003.

We can make a good case on behalf of relatively high-wage hospitals that CMS should not update the cost component weights in FY 2006 to make up for not updating the weights in FY 2003. However, we would support CMS updating the weights in FY 2006 *if* the Agency also designated professional liability insurance as a labor-related cost. These costs are clearly wage-related—indeed, they are reported in the wage index—and are clearly locally determined. We believe that the failure to include professional liability insurance in the wage-adjusted portion of the standardized amount in the past was a grave oversight. Including this important cost component in the labor share would bring it up to 71.3%, which is virtually the same as the current labor share of 71.1%.

Outliers

CMS estimates that outlier payments in FY 2004 made up only 3.5% of total inpatient PPS payments, which is 31% less than the amount of funding that the hospitals contributed to the pool. We are compelled to express, once again, our concern about the Agency's inability to estimate the outlier threshold to a reasonable degree of accuracy.

Hospital Quality Data

The health care industry is in the very early stages of implementing electronic health records and the national health information infrastructure. Moving forward is analogous to a baby learning to walk because the systems—and financing—are very weak and the path is strewn with obstacles. Therefore, we agree with Congress and CMS that the appropriate way to implement "pay-for-performance" at this stage is to pay for data submission.

For FY 2006, however, CMS has proposed to make full payment of the annual Medicare inpatient PPS update also contingent on hospitals passing a data validity test. We believe that data validity is very important and appreciate the opportunity to work with IPRO (our quality improvement organization) and CMS on the data validation process. However, we believe that the current data validation process is, itself, not yet sufficiently valid to be tied to the payment. The problems are so fundamental that we believe they must be resolved before CMS penalizes hospitals financially. Therefore, we recommend that CMS not yet tie the full payment update to data validity.

The Greater New York Hospital Association has thoroughly catalogued the flaws in the data validation process and we fully support the Association's series of recommendations to correct these flaws.

DRG Reclassifications

We believe that continuous DRG refinement is very important because it allows hospitals to implement new technologies, pharmaceuticals, and treatment protocols while minimizing systematic risk. Therefore, we support CMS's proposed DRG refinements for FY 2006, with two modifications.

First, with respect to the stroke DRGs, 14 and 15, we support the second suggestion made by the representatives of several hospital stroke centers with which CMS consulted regarding recognition of the high cost of tissue plasminogen activator (tPA). This suggestion was to create a new DRG entitled "Ischemic Stroke Treatment with a Reperfusion Agent," which would only include strokes that were caused by clots and treated with tPA, as identified through the procedure code 99.10. Furthermore, we recommend that CMS implement the new DRG in FY 2006 rather than waiting for more data to accumulate, since the incremental cost and effectiveness of this thrombolytic agent are well documented.

Second, with respect to the DRGs involving the implantation of an automatic implantable cardioverter/defibrillator, CMS is proposing to regroup cases without cardiac catheterization, but with cardiac electrophysiologic stimulation and recording studies (EPS), from DRGs 535 and 536 to DRG 515, Cardiac Defibrillator Implant without Cardiac Catheterization. CMS's data show that the average cost of cases with EPS is significantly higher than the cost of cases without EPS and that the volume of cases with EPS is also significant. Therefore, we recommend that CMS create a new DRG for cases with cardiac defibrillator implant without cardiac catheterization, but with EPS.

Thank you for considering these comments.

Sincerely,

Dennis W. Mitchell, FHFMA
Chief Financial Officer

445

Q Data

Submitter : Mrs. Janice Pope **Date:** 06/24/2005

Organization : Wyoming Association of Health Quality

Category : Health Care Provider/Association

Hefter
Hartstein
Bodden
Hammel

Issue Areas/Comments

GENERAL

GENERAL

See Attachment
COMMENTS FOR CMS RATE INCREASES FOR INPATIENT STAYS IN ACUTE CARE HOSPITALS

1) The payment system is based on validation data that is not up to date. Could more current data be used for determining the FY2006 APU? .
2) Please provide Hospitals with data reports that are current and an opportunity to check and double check data for errors. Time frames are too short and offer the facilities very little time to address system changes.
3) Perhaps resolving validation reliability issues and increasing the number of charts for analysis would resolve questionable reliability. Five (5) charts does not do justice to the hospitals.
4) CMS needs to be prepared to follow through on timeliness and accuracy of data.
5) Please establish an appeal procedure for those hospitals the CMS decides do not qualify for the FY2006 APU
6) There is concern that vendors have not been required to resolve issues with the Clinical Warehouse reporting.
7) The voluntary reporting system should not be designed as a punitive system, but rather as a positive development of a data reporting system involving time for cycles of improvement and ongoing process change to make the system a valid reporting mechanism.

CMS-1500-P-731-Attach-1.DOC

Attachment to #731

COMMENTS FOR CMS RATE INCREASES FOR INPATIENT STAYS IN ACUTE CARE HOSPITALS

1) The payment system is based on validation data that is not up to date. Could more current data be used for determining the FY2006 APU? .
2) Please provide Hospitals with data reports that are current and an opportunity to check and double check data for errors. Time frames are too short and offer the facilities very little time to address system changes.
3) Perhaps resolving validation reliability issues and increasing the number of charts for analysis would resolve questionable reliability. Five (5) charts does not do justice to the hospitals.
4) CMS needs to be prepared to follow through on timeliness and accuracy of data.
5) Please establish an appeal procedure for those hospitals the CMS decides do not qualify for the FY2006 APU
6) There is concern that vendors have not been required to resolve issues with the Clinical Warehouse reporting.
7) The voluntary reporting system should not be designed as a punitive system, but rather as a positive development of a data reporting system involving time for cycles of improvement and ongoing process change to make the system a valid reporting mechanism.

446

Submitter : Mr. Dave Hewett **Date:** 06/24/2005

Organization : SD Association of Healthcare Organizations

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1500-P-732-Attach-1.PDF

CAH Reloc

Hafter
Hartstein
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Smith

ATTACHMENT TO #732

South Dakota
Association of Healthcare Organizations

June 24, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011,
Baltimore, MD 21244-1850

Dear Dr. McClellan:

RE: CMS-1500-P; Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2006 Rates; Published May 4, 2005

The South Dakota Association of Healthcare Organizations (SDAHO) appreciates the opportunity to comment on the above referenced proposed changes to the Inpatient Prospective Payment System (PPS) for federal fiscal year 2006.

CRITICAL ACCESS HOSPITALS

Relocation of a CAH Using a Necessary Provider Designation:

There are 37 community hospitals that are designated and 36 operating as CAHs in South Dakota. Several of these CAHs were grandfathered into the CAH program from the earlier EACH/RPCH program. 20 CAHs were designated based upon the necessary provider of health criteria within the state rural health plan. In the Medicare Modernization Act of 2003 (MMA), it included a sunset provision, effective January 1, 2006, that eliminates the state's authority to grant necessary provider of health designations. However, MMA did provide a grandfathering provision that allows any CAH that is designated as a necessary provider of health prior to January 1, 2006 to maintain its necessary provider designation.

The proposed rule endangers CAHs that are designated as a necessary provider of health because it proposes new parameters that will severely weaken the ability of CAHs to replace their current facilities. CMS is proposing that CAHs designated as a necessary provider may only retain their CAH status if they build a replacement facility within 250 yards of its current location or if the CAH can demonstrate their construction plans began before December 8, 2003. For a hospital that moves any further, the hospital will have to show that it:

- Submitted an application to the state agency for relocation prior to January 1, 2006;

3708 West Brooks Place•Sioux Falls, SD 57106-4211•Phone: (605) 361-2281•Fax: (605) 361-5175•Website: www.sdaho.org

- Meets the same criteria for necessary provider status that it did when it originally qualified (e.g., in a health professional shortage area (HPSA) and remains in a HPSA);
- Serves the same community (75 percent of same population, 75 percent of same services, 75 percent of the same staff);
- Complies with the same conditions of participation; and
- Was "under development" as of December 8, 2003 using similar criteria as the specialty hospitals guidelines (architectural plans, financing, zoning, construction bids, etc).

The arbitrary date proposed by CMS is unrealistic and is a broad overreach of CMS authority. It puts in jeopardy many relocation projects that were started in the past 18 months since the passage of the MMA. This was clearly not the intent of Congress to prevent existing CAHs designated as a necessary provider to be perpetually prohibited from replacing or relocating their facility, which are often 40-50 years old. In addition, several South Dakota CAHs are land-locked because they are located in residential areas. Therefore, these facilities will be forced to choose between building a replacement facility and jeopardizing their CAH designation or spending countless additional dollars in improving and maintaining a deteriorating facility. This misguided policy does not make any reasonable sense. **SDAHO agrees with the suggested comments and recommendations of the AHA and would encourage CMS to remove the arbitrary date restrictions for relocation facilities and consider easing the proposed restrictions that discourage CAHs to relocate regardless of the improved benefits to beneficiaries.**

Thank you for considering our comments on the proposed rules changes. Please contact the SDAHO at 605-361-2281 if you have any questions regarding these comments.

Sincerely,

Dave Hewett

David R. Hewett
President/CEO

cc. South Dakota Congressional Delegation

447

Labor/S
Transfers
CAH Reloc
WI/DC

Submitter : Mr. Michael Hill
Organization : NH Hospital Association
Category : Hospital
Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

CMS-1500-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule.

CMS-1500-P-733-Attach-1.DOC

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Hartstein
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CMS made an evaluation in 2002 and proposed a 72.495% labor share, which it subsequently backed away from. Then Congress required that any hospitals with an area wage index of less than 1.0 receive a labor share of 62.0% if that was more beneficial. Decreasing the labor share proportion is predisposed to positively impact rural hospitals.

In CMS analysis it related and compared the 1992 based labor share weights (71.066%) to the 2002 based labor share weights (69.731%). CMS does not draw any conclusions regarding the related shifts by line item. What CMS should be evaluating is why the proportions changed from 1997 data, which the agency decided not to use. This represents the true question. The real issue to be questioned is why the labor share went from 71.066% (1992) to 72.495% (1997) to 69.7315% (2002). These changes raise questions about 1) the veracity of the data, 2) the change in base cost data, 3) the effect of proxy changes on the trending, 4) consistency of CMS methodology, and 5) other factors. CMS did not seem to analyze these issues or seems to have ignored them. CMS needs to address why it believes that the labor share proportion is fluctuating (regardless of whether the agency used the 1997 based labor share proportion). The agency needs to concern itself with why this fluctuation occurred and whether it was caused by any methodological or data change and whether such a change was appropriate. This type of analysis has not been performed - rather the agency has chosen to compare the 1992 weights to the 2002 weights which show the lest amount of variation.

If CMS were to have compared the 2002 weighted labor share with the 1997 labor share it would have seen a greater variation among the elements. Some variations would have been 100% greater, which would have raised the question of why such variation occurred. CMS discussion in the rule did not focus on the 1997 to 2002 variation. In fact, CMS was almost dismissive of the fact that the 1997 proportions existed.

The fact is that the 1997 data increased labor share proportions and in turn the impact of the AWI. This would have adversely impacted the rural providers. At that time CMS knew of the Senate interest in protecting rural providers from this effect. Coincidentally, CMS pulled back from implementing this change. Then the Senate pushed to put in place the 62 % labor share for providers with AWIs less than 1.0. Thus, rural hospitals are now protected.

The current labor share proposal would provide a reduction to urban hospitals and would not fundamentally benefit the rural hospitals because they are already protected by the 62% labor share requirement. Thus, CMS should not implement the revised labor share proportions.

In reviewing the proposed rule, it is not clear that the budget neutrality adjustment incorporates CMS revision to the labor share proportion. The budget neutrality adjustment for the area wage index and recalibration is a slightly positive number (greater than 1.0) while all of the other budget neutrality factors are negative. If the labor share adjustment as proposed were implemented, payments would decrease as a result because the higher AWI areas would receive lower payments. Because the majority of discharges and payments are paid at AWIs above 1.0 one would expect that a shift to paying these discharges at 1.0 would reduce total payments. Due to these lower payments the system would lose aggregate dollars it there is no budget neutrality adjustment for this purpose. Thus a relative high budget neutrality factor (higher than presented in the rule) would apply.

It appears that CMS used the same base rates from FY 2005 then changed the labor non-labor share proportion. If there was no explicit adjustment to account for the fact that the labor share reduction reduced Medicare expenditures, because the AWI is applied to a lower portion, then there is a savings to the trust fund in the absence of a budget neutrality adjustment.

upgrading infrastructure to support utilities and air handling, modernizing telecommunications to support health information technology, or other essential upgrades. **Such improvements will undoubtedly result in higher quality care, better patient outcomes, and more efficient service.**

Many facilities need to, or choose, to rebuild on a new site to be closer to a highway, connect to municipal water and sewer, because of seismic safety concerns, or other reasons that again, will improve patient safety and the quality of care provided. In addition, many CAHs are landlocked with little or no room for expansion, thus they have no choice but to relocate if they must rebuild. **Facilities that must relocate to make critical safety improvements should not be penalized for circumstances beyond their control and barred from moving.**

NHHA believes CMS has gone too far in trying to paint hospitals that are moving a few miles from their current location as having ceased business and reopened as a *new provider.* This shows a general lack of knowledge about rural areas. These CAHs are integral to their communities and often one of the biggest employers. Moving down the road will not demonstrably change the population served. **We further assert that CMS automatically should consider any CAH that moves within five miles to be rebuilding and not relocating and thus the same provider.**

If a CAH moves further than five miles, and CMS is concerned about whether the same population is being served, then we would recommend an approach similar to the 75 percent test described earlier. However, given that these criteria would have to withstand the changing health care landscape for the indefinite future, we believe some modifications to the test of whether the newly relocated provider is serving 75 percent of the same population, with 75 percent of the same staff, and providing 75 percent of the same services are warranted.

For instance, natural changes in demographics and the practice of medicine will occur over time that may necessitate a change in services when a hospital is rebuilt. Or, a greater reliance on new technology may limit the number or type of staff needed at a newly built facility. **Some flexibility in the measures is needed to allow for such expected changes in the needs of the community.**

Therefore, NHHA recommends that CMS alter its criteria to allow three out of five to be satisfied. In addition to the staff, services and population measures, CMS should consider adding a needs assessment and cost comparison. For example, if a CAH can show through a needs assessment that the change in services provided would be appropriate, then the test of 75 percent of the services should not need to be met. If a CAH has undertaken a cost comparison that shows that a new facility on another site would be less expensive than rebuilding on the current location, then only two other measures should need to be satisfied. **A combination of criteria suggested would offer CAHs some flexibility and allow for the natural development and maturation of the CAH and the community.**

We also encourage CMS to consider special provisions for hospitals that are merging. Under these circumstances, the two hospitals may not be able to meet the criteria. In these cases, CMS should make determinations on a case-by-case basis. If the merger meets the needs of the communities, then CMS should consider it an appropriate and allowable relocation.

Regardless of what criteria are chosen, CMS should clearly delineate them in advance. For example, when counting the staff, how should the hospital ascertain if the staff would continue employment at the new location? How would a CAH compare the population they serve to a hospital that has yet to be built? Would the services be considered based on departments or actual individual services? Is the fact that you plan to provide lab services in general sufficient? Moreover, the comparison between the old facility and the soon-to-be built facility should be a one-time comparison based on the facts at the time of the application. **CAHs need clear expectations and advanced warning of the standards to which they will be held.**

CAHs are the sole providers of inpatient acute-care services in their communities and often outpatient and long-term care services. Facilities that convert to CAH status do so because of their dire financial conditions under the prospective payment systems. It is thus, unlikely that they would

be able to successfully convert back to the inpatient PPS. In addition to the lower reimbursement there would be other hurdles, such as getting licensed for additional beds in certificate of need states

or hiring additional staff to expand services when there are shortages in many areas, that would need to be surmounted in an effort to build volume to survive under the PPS. For many of these CAHs, loss of their status would force them to close. Given the role of these facilities in their communities, such closures would have devastating affects on rural healthcare access.

We urge CMS to rescind this overly restrictive policy and allow necessary provider critical access hospitals to relocate as needed to improve the care of and meet the needs of their communities. Instead, CMS should expand and use the criteria recommended above.

WAGE INDEX DATA

We write to assure that the wage data for CAHs is appropriately removed from the New Hampshire area wage data. The various data sources we have examined do not clearly indicate to us that these providers are excluded. A specific provider involved is Androscoggin Valley Hospital (AVH) (30-0022). Another provider that has converted to CAH status but whose data remains in the New Hampshire area wage data is Monadnock Community Hosptital (MCH) (30-0007).

AVH is located in rural New Hampshire and was designated as a CAH effective 12/30/2004. Because of the timing of the notification of the hospital, this hospital's data was included in the February 2005 PUF (public use file). It is also listed in Table 2 of the proposed rule and the June 1, 2005 corrected Tables. In addition, the data for this provider appears to be included in the calculation of the rural AWI in the proposed rule and June 1, 2005 corrected Table 4A, as the AWIs in Table 4A of the Federal Register and corrected Table 4A are the same. However, the data for this provider is not in the May 2005 PUF.

AVH was initially notified that it was a CAH in a letter from CMS dated February 16, 2005. The hospital did receive a subsequent corrected letter relating to their CAH status dated March 8, but that letter did not change the fact that the hospital was a CAH prior to February 16, 2005.

MCH had a similar experience by receiving two letters from CMS, one dated in early February 2005 and the corrected letter in March 2005. However, the corrected letter did not change the hospital's CAH effective date, which remains at 12/27/04.

The fiscal intermediary was notified of this in February 2005 and then contacted CMS as did a representative of NHHA and both were informed that the data for Androscoggin Valley Hospital would be removed which seems to be confirmed by its exclusion from the May 2005 PUF. Based on the above, both of these providers should be excluded from the AWI data in the final rule. Accordingly, we are writing to assure that this will occur.

NHHA appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please feel free to contact me at 603/225-0900.

Sincerely,

Michael Hill
President

448

Submitter :

Date: 06/24/2005

Organization :

Category : **Device Industry**

Issue Areas/Comments

GENERAL

GENERAL

We oppose the current expansion of the postacute care transfer regulation. See Attached.

CMS-1500-P-735-Attach-1.DOC

Transfer
NT
IMPACT

Heffer
Hartstein
Walz
Hart
Treitel
Kraemer
Brooks
Gruber
Fagan
Kelly
Hare

Attachment to #735

June 24, 2005

The Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates, Proposed Rule – Section "Post Acute Transfers"

Dear Dr. McClellan:

Thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule for the Fiscal Year 2006 Inpatient Prospective Payment System. ETHICON, INC, a Johnson & Johnson Company, is a medical device company focused on wound management, women's health, cardiovascular surgery, and surgical wound closure. We are deeply concerned with the negative impact the proposed transfer rule changes will have on Medicare beneficiaries and the hospital community.

Our concern is related to the possible change in criteria, which will result in the expansion of the post-acute care transfer policy to an additional 223 or possibly all the Diagnostic Related Groups (DRGs). We believe that implementing this provision will negatively affect Medicare patients' overall care and endanger the financial health of hospitals.

The proposed policy contradicts the premise of a Prospective Payment System (PPS), which is based on a system of averages. The proposed transfer policy will reduce payment for any discharge that meets the various sets of criteria; one major element being, the patient is discharged before the geometric average length of stay. The post acute care setting helps to ensure patients receive the highest quality care in the most appropriate clinical setting, within the overall continuum of care. This expansion of the proposed provision would penalize hospitals for making good clinical decisions with proper discharge plans, and may ultimately limit their purchase of new and innovative technology. These technologies may assist patients in quicker recovery times and ultimately reducing their inpatient hospital length of stay before a DRG geometric average length of stay.

These drastic changes to the inpatient PPS system will put great financial strain on the hospital community, forcing many facilities to make tough choices. Facilities may have to institute stringent and expensive clinical policies/protocols, and information systems to monitor Medicare patients' impeding discharge status

and length of stay. Clinical decisions may turn into more of a financial decision, where hospitals keep Medicare patients in longer than actually necessary, to achieve the full DRG payment, instead of a reduced per diem payment. Hospitals may choose to discharge patients at the earliest possible moment, before a financial loss is achieved. This early discharge will limit a Medicare beneficiary's option in the post acute care treatment area, since may home care agencies, subacutes, and long term care facilities have initial waiting lists before a patient can be admitted to in this setting.

Early transfer of patients from an inpatient setting to a post-acute provider should be naturally accounted for in the charge-based MedPAR database. Assuming that hospitals accurately reflect in their charges the reduced length-of-stay and lower cost derived from patients that are transferred early, the post-acute transfer policy is not necessary. Overtime, early patient transfer associated with these DRGs should be accounted for in the MedPAR database and the relative payment rates established by the agency.

Another likely result of the expansion of the Transfer Policy to either all (which fit the criteria) or an additional 223 DRGs will be the limitation of patient access to innovative, high quality medical technology (s), covered under the DRG system. If the proposed Transfer Provision is expanded, hospitals will have to evaluate many medical technologies purely on their economic benefit to the financial viability of the institution rather than on their overall clinical value to the Medicare beneficiaries. Many new technologies potentially reduce the Medicare patients' length of stay, while adding incremental cost to the early days of the case cost. Hospitals will bear the incremental cost of a new technology that lead to reduced length of stay, and will receive less reimbursement, based on these changes. We understand the Medicare system is designed to capture the "cost" of these new technologies, over time, usually 2-3 years, however many providers cannot wait for the increase in reimbursement in those associated DRGs, based on their dwindling margins. Also, during that same period, their associated DRG payments are being reduced through the negative affect of the proposed transfer policy.

We believe the expansion of the Transfer Provision will put great financial strain on hospitals and limit patient access to new and innovative medical technologies, and therefore we support retaining the current transfer methodology, until Medicare conducts an analysis of patient severity payment process in response to MedPAC recommendations. It would make sense to conduct the evaluation of the Post Acute Care Transfer Policy on DRG payments within this scope of the overall analysis.

We look forward to the published comments and the possible rule changes before the final rule is implemented on October 1, 2005.

Thank you for your review and consideration of these comments. If you have any questions, please contact me at 908-218-2358.

Sincerely,

Scott Wolven

Attachment to #735

Reimbursement Director
ETHICON, INC.
Route 22 West
P.O. Box 151
Somerville, NJ 08876
908-218-2358
Swolven@ethus.jnj.com

449

Submitter : Mr. Edward N. Goodman

Organization : VHA Inc.

Category : Hospital

Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment...

CMS-1500-P-737-Attach-1.DOC

Teansfer
Labor/S
CAH Reloc
CAH LUSAR
LTC-DRGs
SpH
Payment Rate/Outliee
Q Data
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Seifert
Knight
Collins
Money
Smith
Hudson
Richter
Romano
Treitel
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ATTACHMENT TO #737

June 24, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Attn: CMS-1500P
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Room 443-G, Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1500-P – Comments Regarding Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates

Dear Administrator McClellan:

On behalf of VHA Inc. ("VHA"), I am writing to provide comments on the "Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates," published in the May 4, 2005 Federal Register (the "Proposed Rule").[1] Given the significant impact of the proposed changes to the inpatient prospective payment system ("IPPS") and related regulations, we appreciate your consideration of our concerns and requests, as set forth below.

VHA is a national alliance of leading not-for-profit health care organizations that work together to improve the health of the communities they serve. VHA delivers industry leading supply chain management services and enables regional and national member networks to improve clinical and operational performance and to drive sustainable results. Based in Irving, Texas, VHA has 18 local offices serving more than 2,400 health care organizations across the United States.

I. Post-acute Care Transfers

CMS is proposing to expand dramatically its post-acute care transfer policy by adopting new criteria for determining which DRGs are subject to the policy. CMS' proposal would increase the number of DRGs subject to the transfer policy from 29 to 231 — about half of all DRGs — and would result in an $894 million reduction of overall hospital payments, according to calculations by the American Hospital Association ("AHA").

VHA strongly opposes the proposed revisions to the post-acute care transfer policy and urges CMS to refrain from implementing this ill-advised proposal. This proposal does

[1] 70 Fed. Reg. 22,305 (May 4, 2005).

not serve the best interests of patients and their caregivers, and runs contrary to the purpose and structure of the inpatient prospective payment system itself. Under the IPPS, a hospital is paid a set fee for treating patients in a single DRG category, regardless of the actual costs incurred by the hospital to provide that care. The practical effect of the IPPS has always been that hospitals will lose money on some discharges and make money on others.

Expansion of the transfer policy to such a large number of DRGs distorts the system. Hospitals would be penalized when they transfer a patient to a post-acute care facility prior to the average length of stay (that is, a hospital will not receive the full reimbursement for such a discharge), but hospitals would not be given any relief (i.e., higher payments) when a patient remains in the hospital beyond the average length of stay for the DRG, unless the patient becomes an outlier. In effect, CMS' proposed transfer policy unfairly punishes hospitals when they are able to provide appropriate and necessary care in an efficient manner.

II. Labor-Related Share

CMS proposes decreasing the labor-related share by 1.4 percent (from 71.1 percent to 69.7 percent) for hospitals with an area wage index ("AWI") that is greater than 1.000. This change — which CMS attributes to the use of new data and the removal of postage from the labor-related share — will have a negative impact on the hospitals affected (i.e., those with an AWI greater than 1.000).

VHA does not support CMS' proposed method for determining the labor-related share. If CMS is going to change the manner in which the labor-related share is calculated, CMS should do so by developing a more comprehensive alternate methodology that is reliable and accurate, rather than merely removing one item (i.e., postage) from the labor-related categories. **VHA recommends that CMS continue to use the labor-related share from FY 2005 (i.e., 71.1 percent), until CMS is able to thoughtfully examine other methodologies for computing the labor-related share.**

III. Critical Access Hospitals – Maintaining CAH Status for "Necessary Providers"

Historically, a state could waive the location requirement of the CAH regulations by designating an otherwise qualified hospital as a "necessary provider." In the Medicare Modernization Act of 2003 (the "MMA"), Congress terminated a state's authority to designate hospitals as necessary providers, effective January 1, 2006. However, Congress also provided that those hospitals which qualified as CAHs because they had been designated as "necessary providers" by the state are grandfathered and, in turn, continue to be treated by Medicare as a CAH. Thus, Congress intended that those CAHs designated as "necessary providers" continue to function as CAHs. Contrary to Congress' wishes, CMS is proposing to strip these hospitals of their necessary provider CAH status if the hospitals must relocate.

Under CMS' proposal, a hospital's ability to retain its CAH status when building a new facility will depend first on whether the new facility is considered a replacement or relocation (defined in the Proposed Rule). A facility will be considered a replacement only if it is located on the same campus as the previous facility. Replacement facilities generally will retain their status as a necessary provider and, consequently, as a CAH. If a necessary provider CAH were to build a new facility more than 250 yards from the existing campus, the facility generally would be considered a relocation and will lose its CAH status, unless the hospital "embarked on a replacement facility project" before December 8, 2003 (i.e., the date Congress enacted the MMA) and meets other stringent requirements.

VHA believes this proposed rule is overly restrictive and is contrary to the intent of Congress. The rule arbitrarily limits the ability of necessary providers to rebuild (and improve) their facilities based on the location of the construction. Thus, the necessary provider CAH that constructs a new facility within 250 yards of the existing facility may continue to be treated as a grandfathered CAH, while the same hospital would sacrifice its CAH status if it constructs a new facility 300 yards away from its existing location. The proposal does not take into account any facts and circumstances of the proposed move, such as if patient access or facility security will be improved by locating a new facility "off campus." A hospital should not be forced to select a sub-optimal location in order to retain its CAH status.

Moreover, the exception to this general prohibition — allowing a hospital to retain CAH status only if the replacement facility project was under development by December 8, 2003 — is arbitrary and is exceedingly limiting. We do not see any justification for tying this deadline to the date of the MMA's enactment, especially given that the MMA itself does not prescribe such restrictions. **VHA strongly urges CMS not to finalize this policy. We believe a necessary provider CAH should be allowed to relocate within its current service area, and we believe reasonable criteria — something other than a 250 yard requirement — can be developed to effectuate such a policy.**

IV. Critical Access Hospitals – "Lugar Counties"

CAHs generally must be located in rural counties (i.e., not MSAs). Due to revised census data and new MSA definitions, certain counties that were not part of an MSA in FY 2004 became part of an MSA in FY 2005. Last year, CMS revised its CAH regulations to permit CAHs located in these counties to retain their CAH status through the end of FY 2006 (during which time the hospitals may seek reclassification as rural facilities before FY 2007 pursuant to the MGCRB reclassification process). Per the Proposed Rule, CMS plans to clarify its regulations to specify that the regulations also apply to CAHs that were located in rural counties in FY 2004, but were reclassified as "Lugar counties" in FY 2005 due to revised census data and

new MSA definitions.[2] **VHA appreciates and supports this proposed clarification, as it ensures that CAHs located in counties that — either technically or effectively — lost their status as "rural" will continue to operate as CAHs until FY 2007, during which time they may seek reclassification thought the normal reclassification process.**

V. LTCH-DRGs

CMS is proposing a new methodology for determining DRG relative weights for long term care hospitals ("LTCH") for FY 2006. Significantly, CMS proposes removing from its calculations of DRG weights those cases representing statistical outliers and cases with a length of stay ("LOS") of seven days or less (among other changes). According to CMS, these outlier and short-stay cases represent "aberrations" in the data that would distort the measure of average resource use. CMS estimates its proposed recalibration of the LTCH-DRG weights would reduce Medicare payments to LTCHs by 4.6 percent, or $135 million, in FY 2006 alone. **VHA is concerned about this proposal**, under which CMS is removing an excessive number of relevant cases from the calculations of LTCH-DRG relative weights. The prospective payment system is, in essence, a system of averages; by leaving so many cases out of the relative weight calculations, the prospective payment system itself becomes distorted.

VHA respectfully asks CMS to reconsider its implementation of the proposed reweighting methodology. At a minimum, CMS should consider taking steps to mitigate the impact of its proposal for FY 2006. For instance, CMS could implement a policy under which no DRG weight is reduced by more than some ceiling level (or is only partially reduced once a threshold reduction level is reached). We believe there may be alternative approaches for reducing the impact of CMS' reweighting methodology, and we encourage CMS to explore all its options before finalizing the Proposed Rule.

VI. Specialty Hospitals (also known as "Limited-Service Hospitals")

In the Proposed Rule, CMS expressed a concern that some existing and proposed specialty hospitals may primarily be furnishing outpatient care, rather than inpatient care. CMS emphasized that a facility that is not primarily engaged in furnishing services to inpatients cannot be considered a "hospital" for Medicare purposes. Subsequently, CMS announced that, over the next six months, it will undertake a review of its procedures for enrolling specialty hospitals in Medicare and will take steps to reform Medicare payments that may provide specialty hospitals

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[2] A "Lugar county" is a rural county that is adjacent to one or more urban counties and is treated by CMS as if it is part of the urban MSA to which the greatest number of workers in the county commute, under certain conditions. While CMS treats such counties as part of an MSA, they are not technically part of an MSA.

with an unfair advantage over other types of providers, such as community hospitals and ambulatory surgical centers.[3]

VHA applauds CMS for its decision to undertake a critical examination of specialty hospitals and to delay approving new specialty hospitals. Presently, specialty hospitals are able to treat the most profitable patients and furnish the most profitable services, while full-service community hospitals are left to treat a disproportionate share of the less profitable (or non-profitable) cases. VHA believes CMS should scrutinize the current processes for approving new specialty hospitals and suspend enrollment applications in the interim. By effectively extending the moratorium on new specialty hospitals until January 2006, CMS is providing time for Congress, CMS, and all stakeholders to reasonably consider the appropriate ways to address the problems associated with specialty hospitals.

VII. Outlier Payments

CMS proposes increasing the FY 2006 fixed-loss cost outlier threshold from $25,800 to $26,675. **VHA is concerned that the proposed threshold is too high, which in turn may compromise hospitals' access to outlier payments needed to cover the care associated with the treating particularly high-cost patients.** Over the past two fiscal years, the outlier threshold has been set too high. In FY 2005, actual outlier payments are projected to be 0.7 percent less than the amount withheld from hospitals that year. In FY 2004, actual outlier payments were 1.6 percent lower than the amount withheld that year.

Based on analyses by the AHA, the methodology CMS is using to estimate the fixed-loss cost outlier threshold results in an inappropriately high threshold, effectively cutting payments to hospitals. **VHA believes CMS should consider adopting a more appropriate methodology, incorporating both cost inflation and charge inflation, in order to set the outlier threshold level at an accurate and appropriate level.** VHA endorses the proposal set forth by AHA, according to which the outlier threshold for FY 2006 would be set at $24,050.

VIII. Hospital Quality Data

By law, CMS must reduce the standard market basket update by 0.4 percent for any inpatient PPS hospital that does not submit data on a set of ten quality indicators previously established by HHS.

Under the Proposed Rule, a hospital must satisfy CMS' data validation requirements in order to receive the full (non-reduced) payment update. CMS proposes using a chart audit

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[3] CMS Outlines Next Steps as Moratorium on New Specialty Hospitals Expires (CMS Fact Sheet, June 9, 2005, available at http://www.cms.hhs.gov/media/press/release.asp?Counter=1478).

validation process in which five charts from a hospital's third quarter 2004 data submission will be pulled and reviewed by a CMS contractor. The contractor will calculate the percent agreement for all of the variables submitted in these five charts — irrespective of whether they are related to the ten quality measures. If there is at least 80 percent agreement between the contractor's abstraction and the hospital's submission, the hospital will have met CMS' validation requirements and will receive the full payment update. If the hospital does not meet these validation requirements, a second assessment is conducted using only the data relating to the ten quality measures that are required to be collected. If there is at least 80 percent agreement between the contractor's abstraction and the hospital's submission, the hospital will have met the validation requirements and will receive the full payment update. However, if the hospital does not meet the validation requirements during this second phase of the review, the hospital may appeal the contractor's results. If the appeal is not successful, the hospital may submit five randomly selected charts from the fourth quarter of FY 2004 for a review similar to the initial review, after which CMS will use the charts from both quarters to determine if the hospital passes the 80 percent validation requirement.

While VHA supports a robust validation process to ensure data accuracy, we have concerns with the methodology proposed by CMS. Past experience with CMS' validation process demonstrates that the process itself is unreliable and is in need of improvement. Failure to obtain the full payment update would be a serious detriment to a hospital and, in turn, we believe it is inappropriate to tie a hospital's update to a flawed verification process. **Thus, VHA respectfully requests that CMS not pursue this proposed validation process and consider other methods for ensuring data accuracy. In the interim, we believe the full market basket update should be conferred to hospitals meeting the data submission requirements. CMS should link hospitals' updates to the data validation process only after a reliable validation process is developed and tested.**

On a related issue, the Proposed Rule would require hospitals to submit the required ten quality measures each quarter. The data must be submitted on time and pass all required edits and consistency checks, or the hospital will receive the reduced payment update (2.8 percent) for FY 2006. As a practical matter, it takes a significant amount of time for a hospital to receive feedback on a particular quarter's data submission. In most cases, feedback is not received until after the hospital is well under way with its data collection for the next quarter. CMS must recognize that hospitals may not be able to reasonably implement changes for one quarter based on feedback received about the previous quarter's submission. **VHA encourages CMS to modify its rules to allow hospitals a reasonable time frame — such as 120 days — for modifying its data collection process based on feedback from CMS' contractors. Similarly, any validation rule changes made by CMS should not be effective until at least 120 days after CMS issues notice of these changes, to provide sufficient time for hospitals to make appropriate changes.**

IX. Occupational Mix

CMS proposes continuing to phase in the occupational mix adjustment to the wage index so that only 10 percent of the wage index for FY 2006 would be adjusted for occupational mix. This is the same approach taken by CMS during FY 2005. **VHA supports CMS' proposal,** as it minimizes the financial impact of the occupational mix adjustment on hospitals. Given CMS' lack of confidence in the accuracy and completeness of the data used to create the occupational mix adjustment, VHA appreciates CMS' decision to implement this statutorily required change in a measured fashion.

X. New Technology Threshold

In the Conference Report to the MMA, Congress directed CMS to "consider increasing the percent of payment associated with the add-on payments up to the marginal rate used for the inpatient outlier."[4] In both FY 2004 and FY 2005, the add-on payment level for new technologies was set at 50 percent of the difference between the standard DRG payment and the cost of the procedure using the new technology. Last year, VHA and numerous other commenters urged CMS to raise the add-on payment level for new technologies from 50 percent to 80 percent of the difference between the standard DRG payment and the cost of the procedure using the new technology, consistent with Congress' suggestion. **For FY 2006, VHA again urges CMS to raise the add-on payment level for new technologies from 50 percent to 80 percent,** which can be done without reducing payments for other services.

* * * *

In closing, on behalf of VHA and its members, I would like to thank CMS for providing us this opportunity to comment on the Proposed Rule. Please feel free to contact me at (202) 354-2607 if you have any questions or if VHA can provide any assistance as you consider these issues.

Respectfully submitted,

Edward N. Goodman

Edward N. Goodman
Vice President, Public Policy
VHA Inc.

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4 House Conference Report No. 108-391, 2004 U.S.C.C.A.N. 1808, 2016 (Nov. 21, 2003).

450

Submitter : Mr. Philip Besler

Date: 06/24/2005

Organization : BESLER Consulting

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-738-Attach-1.DOC

WI/OM
Out-M
Hosp Redes.
WI/Gen
Payment Rates
Transfer
IME
DSH
GME/IRP
GME/Aff
CAH Reloc

Hefter
Hartstein
Miller
Kenly
T. Jones
Treitel
Walz
Hart
Lefkowitz
Ruiz
Truong
Collins
Morey
Smith

provider would receive a higher percentage of the occupational mix data if the results were positive and a lower percentage if the results were negative. CMS should put this type of benefit in place to improve compliance (similar to the quality incentive that exists). BESLER believes that the hospitals' designation in the base year should determine whether the hospital is considered a CAH or not. All CAHs that convert between the base year and the rate year should still be included in the occupational mix calculation. CAHs should not be eliminated from the calculation until the hospital is considered a CAH in the base year used by CMS to calculate occupational mix adjustment.

2. Being as the data used for the proposed occupational mix adjustment is essentially the same data as last year, has CMS given any consideration to adjusting the national average.

3. The chart listed on page 23369 of the preamble only listed 6 of the 7 general service categories and the national average table was not listed. However, this table was mentioned in the preamble.

- **"Out-Migration Adjustment":** This calculation is in its second year of existence. CMS had stated, in the IPPS final rule for FY 2005, that the data for this adjustment would be made available via the public use files. This data has not been released as of the date of these proposed regulations. A step by step calculation, similar to both the average hourly wage and occupational mix adjustments would allow hospitals to verify their amounts, and monitor their overall adjustment.

- **"Out-Migration Adjustment":** Hospitals that reclass to another area are not eligible to receive the out-migration adjustment. CMS should allow hospitals that reclass and receive a diluted reclassified wage index to receive the out-migration adjustment provided it does not exceed the actual wage index for the area to which they are reclassified.

- **"Hospital Redesignations and Reclassifications":** With regard to section 508 of the Medicare Modernization Act, CMS should continue the legislation **but** require all potential qualifying hospitals as well as those currently reclassed to file an application. This would allow CMS to treat this legislation similar to the traditional reclass requirements of both individual and county reclass applications. The 508 should also be continued to prevent large shifts in commuting patterns which will create losses for the hospitals. If CMS allows the legislation to expire, hospitals that had originally qualified but will now witness a reduction in their wage index value greater than 20 percent should be "grandfathered" in to the CBSA that the hospital reclassed into as a result of the 508.

- **"Hospital Redesignations and Reclassifications":** For any hospital that is reclassified from April 1, 2004 through March 31, 2007 under section 508 of the Medicare Modernization Act, that successfully reclasses to another area for FY 2007, they should be able to receive an extension to submit a withdrawal if the expiration date of March 31, 2007 is extended to the end of the fiscal year, yet not published in the proposed rule? Currently hospitals have 45 calendar days from the published date of the IPPS proposed rule.

- **"Wage Index"/"Operating Payment Rates":** CMS should propose now to extend the imputed rural floor to coincide with the existence of a rural floor. This would then put all 50 States on a "level playing field." The remaining States, not involved with the imputed rural floor calculation, have been receiving the rural floor benefit for many years and will continue to benefit in the future.

- **"Post Acute Transfers":** The analysis of post acute transfers does not take into account patients that were admitted from a skilled nursing facility (SNF) and then discharged back to the same skilled nursing facility. A number of Medicare patients are residents of a SNF so regardless of their condition at time of discharge they will be discharged back to the SNF. The post acute transfer policy unfairly penalizes those hospitals that serve a large number of Medicare patients residing in a SNF. BESLER suggests excluding cases from the post acute transfer policy if the admission source is "Transfer from a SNF" and the discharge status is "Discharged/Transferred to a SNF". In reality the SNF is the sole residence for these patients so they are really being discharged to their home. These criteria should apply to *all* DRGs subject to the "transfer rule."

- **"IME Adjustment":** *"IME Adjustment for TEFRA Hospitals Converting to IPPS Hospitals"* CMS is proposing to determine an IME FTE cap for hospitals that no longer qualify for an exclusion from IPPS, or have deliberately changed to become subject to IPPS, based on the cost-reporting period used to determine their direct GME FTE cap (1996 in most cases). CMS states they are aware of only four hospitals where this issue has occurred, however this is not fact. Using the same year that was used to determine a hospital's GME FTE cap can be a problem for those hospitals falling into this classification now or in the future because the required time to retain this data (5 years) has expired. CMS does not believe this will be a significant problem and, therefore, does not address this situation in the proposed rule. BESLER feels this issue needs to be addressed to avoid future problems and to ensure fairness to all teaching facilities.

- **"DSH Adjustment Data":** CMS proposes to make SSI data available to recalculate the SSI percentages based on the hospital's fiscal year. CMS states that the data set available will be the same data set CMS uses to calculate the Medicare fractions for the federal fiscal years but does not state at what level this data will be available. BESLER suggests

that the available data set should be patient level detail including the discharge date for all Medicare beneficiaries.

- **"Graduate Medical Education":** *"Direct GME Initial Residency Period (IRP) §413.79(a)(10)"* CMS is proposing to revise the current policy for weighting the direct GME resident counts for residents that pursue a specialty which requires a clinical base-year training program. CMS is proposing to base the initial residency period on the period of board eligibility for the specialty when a resident matches directly to an advanced program, **prior to commencement of any residency training**, without regard to the fact that the resident did not match for a clinical base-year training program. BESLER acknowledges this is a positive change and commends CMS for revising this policy.

- **"Graduate Medical Education":** *"New Teaching Hospitals' Participation in Medicare GME Affiliated Groups (§413.79(e)(1))"* Currently, an urban hospital that qualifies for an FTE adjustment for residents in newly approved programs are not permitted to be a part of an affiliated group for the purposes of establishing an aggregate FTE cap. CMS established this policy because it was concerned that hospitals with existing programs could circumvent the FTE resident cap by affiliating with the new teaching hospitals. This prevents hospitals from creating new programs to facilitate the transfer of most or all of the residents over to the existing teaching hospital. CMS is now proposing to allow an affiliation agreement as long as there is only an increase to the new teaching hospital's resident cap. This is a positive change however this does not address one issue: all teaching programs must meet specific teaching requirements. These requirements may necessitate a new teaching facility to rotate their residents to another hospital. With the current GME/IME changes taking place, it may become more difficult for the new teaching facility to find a hospital that will take the residents without an affiliation agreement unless the new teaching facility agrees to retain the burden of the expense while the residents are rotating to the other hospital site. BESLER suggests CMS allow the new teaching hospitals to be part of an affiliated group whereby their cap is decreased as long as the new teaching facility can document the residents rotated to the other hospital site no more than 25% during the cost report period. That is, at least 75% of each resident's total worked hours must be at the new teaching facility.

- **"Critical Access Hospitals":** *"Proposed Policy Change Relating to Designation of CAHs as Necessary Providers."* Current regulations require a Critical Access Hospital (CAH) to be located more than a 35-mile drive (or in the case of mountainous terrain or secondary roads, a 15 mile drive) from a hospital or another CAH, unless the CAH is certified by the State as a necessary provider of health care services to residents in the area. Under the proposed rule, effective January 1, 2006, the State's authority to waive the location requirement for a CAH by designating the CAH as a necessary provider will be terminated.

  The proposed change, allows no flexibility in the designation of a CAH, and has created a problematic situation for a hospital which is located on an island (only hospital on the island) where the access to the mainland is only by boat or plane. The hospital is less than 35-miles from another hospital on the mainland (air miles), and under existing regulations can be designated a CAH by a State's authority under the necessary provider rule. However, effective January 1, 2006, the proposed rule will eliminate the State's authority, and thus this provider would not be able to seek CAH status. Therefore, BESLER suggests that the CAH location requirements be expanded to inc lude island hospitals that have only air and sea access to the nearest hospital (without consideration to the number of miles between hospitals). Current regulations on the location requirement addresses only drivable miles and therefore would not pertain to the island situation. BESLER believes this additional location requirement is in the spirit of the original CAH regulations, and would eliminate an inequitable situation whereby island hospitals would not be able to seek CAH status.

Thank you for this opportunity to comment.

Respectfully submitted,
BESLER Consulting

Philip A. Besler
President

451

Submitter : Mr. Christopher Bonham
Organization : Morgan Memorial Hospital
Category : Critical Access Hospital
Date: 06/24/2005

CAH Reloc

Hefter
Hartstein
Collins
Smith
Morey

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-739-Attach-1.DOC

Attachment to #739

Christopher W. Bonham
Chief Executive Officer
Morgan Memorial Hospital
P.O. Box 860
Madison, GA 30650

June 24, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1500-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1500-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule.

Dear Dr. McClellan:

I am writing to express my concerns with some very troubling language in CMS-1500-P, the Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates.

Specifically, this proposed rule contains provisions that would require a Critical Access Hospital (CAH) that has *Necessary Provider Status* to build any future replacement facility within 250 yards of its existing facility on land that is adjacent to the current campus and was owned by the hospital prior to December 2003. Otherwise, the hospital will lose its *Necessary Provider Status* and hence its CAH designation. There is language in the rule that would allow a CAH hospital to relocate a facility if it is serving 75% of the same patients with 75% of the same staff provided that the plans to construct the new facility were initiated prior to December 2003.

If the proposed language becomes an official regulation, the effects on CAH hospitals in general, and Morgan Memorial Hospital specifically, will be extremely detrimental. Hospitals will be forced to stay on sites that may no longer be commercially viable, or that may not contain adequate space for the hospital's changing needs. Additionally, many hospitals including Morgan Memorial will be forced to remain in buildings that are 40 to 50 years old and need replacing. In most cases, it is more expensive to renovate and retrofit these older buildings than to build a brand new facility.

Dr. McClellan, this proposed rule appears to be a blatant attempt by CMS to wrest control and power away from local communities. While CMS claims to be enacting the will of Congress as contained in the requirements of the Medicare Modernization Act (MMA), I do not believe preventing CAH hospitals from building replacement facilities in more suitable locations within their existing communities was ever the intent of Congress. Furthermore, with this rule CMS is proposing to treat the relocation of a CAH hospital as a cessation of business which would cause it to lose its provider agreement and provider number with Medicare. There is no basis in law or existing policy for such treatment. Other non-CAH hospitals are not subject to any such treatment when they relocate facilities.

This policy as proposed by CMS is bad for rural hospitals throughout the country, and it is particularly bad for us in Madison, GA. We are currently engaged in the early planning stages of a major facility project at Morgan Memorial that may well lead to a new replacement facility in a few years. Our existing building is aged and obsolete. Our existing campus contains only 4 acres of land, and our experts tell us that we will need at least 15 acres to accommodate our community's future needs. Our hospital's continued success is absolutely dependent on moving into a new facility within the next 3 to 5 years. Otherwise, I fear we will permanently and significantly impaired. As you are well aware, rural hospitals are major economic engines in rural America. Hurting them damages not only the provision of vital healthcare services, but also strikes at the long-term economic vitality of our rural communities.

We at Morgan Memorial Hospital ask that you modify the rule in several ways. **First, remove the arbitrary date restriction that requires hospitals to begin construction planning by December 2003.** CAH Hospitals should be able to relocate a facility at any time so long as they continue to serve the same population as they were when they were first designated necessary providers. This date has no standing or meaning other than when the Medicare Modernization Act became effective. It is absolutely irrelevant to the construction of replacement facilities for CAH hospitals. Nothing in the MMA can be construed imply that congress wished to restrict the construction of replacement facilities for CAH hospitals. The provision of the law that sunsets the states' ability to designate hospitals as necessary providers was clearly intended to limit the creation of new CAH hospitals, but not to restrict essential activities of existing CAH hospitals.

Second, allow CAH Hospitals to automatically be considered as a relocated hospital if they remain within the city limits of their current city, or if their new facility is less than 5 miles from its current location. Most CAH Hospitals serve at least an entire county, and are usually located in one of the small towns (usually the county seat) within the county. They are also usually the only hospital provider in that county. If a hospital stays in the same town, it is

virtually certain that the same population (usually the entire county) will continue to be served by that hospital.

Third, for hospitals that construct a facility outside the city limits of their current city or further than 5 miles, there should be an easily administered test to ensure that the same population is being served in order for the hospital to be considered as a relocated hospital and thereby retain its necessary provider status. The test should be performed prior to the construction, and once approval is obtained, it should be final and irrevocable (barring fraud or some other deception that occurred in the testing process). Hospitals and their lenders cannot take the risk associated with a conditional approval because the costs of losing the CAH designation would likely mean the closure of the hospital and the loss of the sizable investment in a new facility. Tests for the same patient population, the same employee staff, and the same services will need to be based on prospective projections by a competent, unbiased 3rd party since collecting actual data cannot be accomplished until after the completion of construction.

Dr. McClellan, I believe these proposed modifications to rule are reasonable, consistent with existing law, and essential to the vitality and well-being of Critical Access Hospitals. The CAH Program has been remarkably successful in helping small, rural hospitals to survive in an extremely demanding economic environment. As a consequence, they have provided essential, life-saving healthcare services to their communities, and done so at a relatively low additional cost to the federal tax payers. In addition, they are essential to the continued economic vitality of their communities and economic strength is strongly correlated with positive health outcomes. Therefore, I ask most urgently that you enact these modifications to CMS 1500-P.

Thank you for your consideration and for your service to our nation. If you wish to discuss any aspect of this issue, please feel free to contact me at 706-342-1667 extension 206.

Sincerely,

Christopher W. Bonham
Chief Executive Officer
Morgan Memorial Hospital

452

Submitter : Thomas Cockrell

Date: 06/24/2005

Organization : South Carolina Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1500-P-743-Attach-1.DOC

Payment Rate/Update
TRANSFER
CAH Reloc
Payment Rate/Outlier
IMPACT

Hefter
Hartstein
Treitel
WALZ
Hart
Collins
Money
Smith
Kraemer

June 24, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1500-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1500-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of the South Carolina Hospital Association's (SCHA) 90+ member hospitals, health care systems and other health care organizations, we appreciate the opportunity to submit comments on the fiscal year (FY) 2006 inpatient prospective payment system (PPS) proposed rule.

While the SCHA supports many of the proposed rule's provisions, we are particularly concerned about the potential underestimation of the market basket, the proposed expansion of the post-acute care transfer policy, the increase in the outlier fixed loss threshold and the potential restrictions on the relocation of critical access hospitals (CAHs) with necessary provider status.

Current law sets the FY 2006 inpatient PPS update for hospitals at the rate of increase in the market basket, now estimated at 3.2 percent. Legislative and proposed regulatory changes, however, along with technical adjustments to ensure budget neutrality would result in a proposed average per case payment increase of only 2.5 percent. At the same time, the current estimates of the actual market basket increase for FY 2005 is 4.1 percent. We are concerned that CMS is dramatically underestimating the market basket for FY 2006. **We request that CMS review and revise the methodology used to determine the projected FY 2006 market basket.**

We are tremendously disappointed that the rule contains a proposal to further expand the post-acute care transfer policy, which would reduce hospital payments nationwide by nearly $900 million in FY 2006 alone. **The projected impact on South Carolina hospitals is a reduction in payments of more than $8.5 million**. This policy is not in the best interest of patients or caregivers. It undermines clinical decision-making and penalizes hospitals for providing the right care at the right time and in the right setting. **This policy must be withdrawn.**

We are concerned that CMS is proposing to increase the outlier fixed-loss threshold despite the fact that CMS did not fully spend the 5.1 percent of funds set aside for such payments in FY 2005. Using the proposed charge inflation methodology will only result in an inappropriately high threshold and a real payment cut to hospitals. Instead, the SCHA joins AHA in recommending a methodology that incorporates both cost inflation and charge inflation. The use of more than one indicator will make the threshold calculation more accurate and reliable.

A state's authority to grant necessary provider status, and thus waive the distance requirement under the CAH program, expires January 1, 2006. However, the Medicare Modernization Act includes a provision allowing any CAH that is designated as a necessary provider in its state's rural health plan prior to January 1, 2006 to maintain its necessary provider designation. CMS' proposed rule would essentially bar necessary providers from ever rebuilding more than 250 yards from their current location. Appropriate and necessary relocations that will undoubtedly result in higher quality care, better patient outcomes and more efficient service should be allowed. **We urge CMS to rescind this overly restrictive policy and allow necessary provider critical access hospitals to relocate as needed to improve the care and meet the needs of their communities.**

The SCHA appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about our remarks, please feel free to contact me at (803) 744-3510.

Sincerely,

Thomas D. Cockrell, FHFMA
Vice President

453

Submitter : Ms. Linda Burke

Organization : Scott

Category : Hospital

Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

See Comment

CMS-1500-P-744-Attach-1.DOC

WI/Gen/update

Hefter
Hartstein
Miller

Attachment to #744

June 23, 2005

Centers for Medicare and Medicaid Services
Attn: Wage Index Team / Division of Acute Care
7500 Security Boulevard
Mail Stop C 4-08-06
Baltimore, Maryland 21244

RE: Comment – Proposed Wage Index Calculation – Overhead Rate applied to Excluded Overhead Salaries.

Provider # 45-0054

Dear Sir or Madam:

Scott and White Memorial Hospital (the "Hospital") has reviewed the FFY 2006 Proposed Rule published May 04, 2005. The Hospital notes that there is a change to the wage index calculation relating to the ratio used to allocate overhead costs to excluded-overhead salaries. As you know, the ratio developed by this method is applied to employee benefit amounts reported on WKS S-3 Part II lines 13, 14, and 18 in order to derive overhead costs attributable to identified excluded-overhead salaries. Based on our analysis of the Hospital's wage index calculation, it appears that the excluded-overhead ratio is 41%. This number is dramatically high. We do not believe that the ratio accurately reflects the overhead costs attributable to these salaries. The overall employee benefit ratio for the entire hospital is 20% (based on proposed wage index data – total benefits divided by total salaries). We do not believe that applying the 41% amount to excluded overhead salaries accurately reflects overhead costs for those salaries under any reasonable cost allocation methodology. We respectfully request that CMS postpone implementation of this change until a more equitable methodology can be determined.

Sincerely,

Linda Burke, FHFMA, CPA
Assistant Executive Director of Finance
Scott and White Memorial Hospital

454

Submitter : Mr. Len Preslar

Date: 06/24/2005

Organization : North Carolina Baptist Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-745-Attach-1.PDF

Transfers

Hafter
Hartstein
Walz
Hart

ATTACHMENT TO #745

Wake Forest University Baptist

Len B. Preslar, Jr.
President and Chief Executive Officer
North Carolina Baptist Hospital
Telephone: (336) 716-4750
Fax: (336) 716-2067

June 24, 2005

Via Electronic Mail and Fascimile

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS 1500-P
P. O. Box 8011
Baltimore, MD 21244-1850

Re: Post Acute Care Transfer

North Carolina Baptist Hospital is a Medicare participating hospital that admits nearly 14,000 Medicare patients each year. We are extremely concerned about the proposed changes to the Post Acute Care transfer policy and the impact to our Medicare reimbursement. We would be willing to discuss this proposed policy further or to offer suggestions which may be helpful in developing post acute payment reform as would be deemed appropriate.

The proposed policy undermines clinical decision-making and penalizes hospitals for ensuring that patients get the most appropriate care in the most appropriate setting. At North Carolina Baptist Hospital we strive to provide excellence in healthcare to all our patients and it is becomes increasingly more difficult with reductions to our reimbursements. We have approximately 450 post acute transfers annually. Under the proposed expansion that number would increase to 815. We estimate the expansion will negatively impact our facility by about $1 million dollars annually.

We believe that ***any*** expansion of the inpatient transfer policy would fundamentally weaken incentives inherent in the inpatient Prospective Payment System and disrupt the continuum of care typical of quality delivery. It penalizes hospitals that try to ensure that Medicare patients receive care in the most appropriate setting.

Please rescind this proposed policy change and allow hospitals to provide quality care to all Medicare recipients.

Sincerely,

Len B. Preslar, Jr.

LBP:KM:kds

455

Submitter : Ben Pully **Date:** 06/24/2005

Organization : Virginia Hospital & Healthcare Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1500-P-749-Attach-1.DOC

MB|H
Transfer
IMPACT

Hefter
Hartstein
Seifert
Knight
Walz
Hart
Kraemer

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

4200 INNSLAKE DRIVE, GLEN ALLEN, VIRGINIA 23060-6712
P.O. BOX 31394, RICHMOND, VIRGINIA 23294-1394
(804) 747-8600 FAX (804) 965-0475

Attachment to #749

June 24, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Resources
Attention: CMS-1500-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: **Comments Regarding CMS-1500-P, Medicare Program; Proposed Changes to the Hospital IPPS and Fiscal Year 2006 Rates**

Dear Sirs:

The Virginia Hospital & Healthcare Association (VHHA) appreciates the opportunity to submit comments on the FY 2006 hospital inpatient prospective payment system (IPPS) proposed rule. The VHHA represents 62 member hospitals and health systems in the commonwealth of Virginia. **VHHA fully supports and echoes the sentiment of American Hospital Association (AHA) executive vice president Rick Pollack's June 24, 2005 letter to Dr. McClellan and the specific comments regarding the proposed changes to the hospital IPPS and FY 2006 rate**. Additionally, VHHA offers the following comments regarding the potential underestimation of the market basket and the proposed expansion of the post-acute care transfer policy on Virginia hospitals specifically.

Hospital Market Basket

The basic premise of the hospital update is for reimbursement rates to keep pace with the average change in the cost of providing inpatient care; rates increasing to offset the increase in costs. As the inpatient payment system is prospective, these cost or price changes must be projected forward to estimate increases for the subsequent year so that an appropriate inflationary update can be determined in advance of payment. The update is not retroactively reconciled to reflect actual price increases for the year. Therefore, a reliable projection methodology is vital to ensure equitable payments.

As noted in the AHA comments, for seven of the last eight years the market basket projection has been lower than the actual increase. For example, the projected increase in FY 2003 was 3.3 percent while the actual increase was 3.9 percent. In FY 2004 the projected was 3.4 percent compared to a 3.8 percent actual. CMS reports that, based on the most recent data, the FY 2005 market basket increase is now estimated to be 4.1 percent compared to the projected 3.3 percent increase that was used to determine the update factor. We are concerned that the methods used to project the market basket increase do not reflect a reliable estimate of hospital cost increases. Given a 4.1 percent cost increase for FY 2005, a projected FY 2006 increase of 3.2 percent does not seem reasonable.

In 2003, nearly three-quarters of Virginia hospitals had negative inpatient Medicare margins. These margins have demonstrated continued decline over the past several years, reflecting in part the imbalance of rate increases to actual cost increases. **We request that CMS review the methodology that was used to determine the projected FY 2005 market basket and revise it for the FY 2006 projection.**

Post-Acute Care Transfers

Medicare patients in certain Diagnosis Related Groups (DRGs) who are discharged to a post-acute care setting – such as rehabilitation hospitals and units, long-term care hospitals or skilled nursing facilities – or are discharged within three days to home health services are considered a transfer case if their acute care length-of-stay is at least one day less than the national average. These cases are paid a per diem rate, rather than a fixed DRG amount, up to the full inpatient PPS rate.

CMS' continued effort to expand the post-acute care transfer policy is troubling. In the proposed rule, CMS discusses the possibility of expanding the policy from 30 to either 231 DRGs, or any DRG that meets the following criteria:

- At least 2,000 discharges to post-acute care;
- At least 20 percent of its discharges are to post-acute care;
- At least 10 percent of its discharges to post-acute care occur before the geometric mean length-of-stay for the DRG;
- A geometric mean length-of-stay of at least three days; and
- If the DRG is one of a paired set of DRGs based on the presence or absence of a comorbidity or complication, both paired DRGs are included if either one meets the first three criteria above.

AHA conducted analyses to better understand the impact of the proposals in the rule as well as the revised list of DRGs potentially subject to the policy. The approach to expand the policy to 231 DRGs will have a devastating impact on hospitals by reducing overall payments by an estimated $894 million when the effects on disproportionate share hospital (DSH), indirect medical education (IME), capital and outliers payments are considered. **The impact on Virginia hospitals is a $19.6 million decrease in overall payments.**

The expansion of the transfer policy undermines the basic principles and objectives of the Medicare prospective payment system. The Medicare inpatient PPS is based on a system of averages. Cases with higher than average lengths-of-stay tend to be paid less than costs while cases with shorter than average stays tend to be paid more than costs. The expansion of this policy makes it impossible for hospitals to break even on patients that receive post-acute care after discharge. Hospitals are disadvantaged if a patient is discharged prior to the mean length-of-stay, and they are disadvantaged if patients are discharged after the mean length-of-stay.

The post-acute transfer policy penalizes hospitals for efficient treatment, and for ensuring that patients receive the right care at the right time in the right place. Hospitals that make sound clinical judgments about the best setting of care for patients – and this setting is often outside of the hospital's four walls – are disadvantaged under this policy. Hospitals should not be

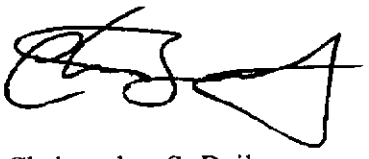
penalized for greater than average efficiency. Particularly, facilities in regions of the country where managed care has yielded lower lengths of hospital stay for *all* patients are disproportionately penalized.

AHA challenges the CMS assertion that the post-acute care transfer policy levels the playing field for rural hospitals that do not have comparable access to post-acute care, and VHHA concurs. AHA compared the rates of discharge to post-acute care for the DRGs to which the post-acute care transfer policy would apply using the 2004 MedPAR data and found that urban hospitals discharged patients before the average length-of-stay 10.6 percent of the time, while rural hospitals discharged patients 9.2 percent of the time. This demonstrates that the transfer policy will have fundamentally the same negative affect on rural hospitals as it does on urban hospitals. Moreover, 4.5 percent of discharges from rural hospitals are to other acute-care facilities, while only 1.6 percent of discharges at urban hospitals are to other acute-care facilities. It is likely that that some of the patients discharged from rural hospitals are then admitted to urban hospitals that then in turn discharge patients to post-acute care. Thus, rural patients have essentially the same access to post-acute care as their urban counterparts.

VHHA objects to an expansion of the post-acute care transfer policy, which is not in the best interests of patients or caregivers. It undermines the basic principles and objectives of the Medicare PPS and clinical decision-making process and penalizes hospitals for providing efficient care at the most appropriate time and in the most appropriate setting. **This provision must be withdrawn in the final rule.**

We appreciate the opportunity to provide comments on the proposed FY2006 IPPS. The June 24 letter and attachments from the AHA touch base on all aspects of the proposed rule, and we again reiterate our full support of their comments and recommended changes. Thank you for your consideration.

Sincerely,



Christopher S. Bailey
Senior Vice President
Virginia Hospital & Healthcare Association
4200 Innslake Drive
Glen Allen, Virginia 23060
(804) 965-1207

456

Submitter : Ms. Becky Miller

Date: 06/24/2005

Organization : Missouri Hospital Association

Category : Hospital

Q Data

Hefter
Hartstein
Bodden
Hammel

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-752-Attach-1.PDF

CMS-1500-P-752-Attach-2.DOC

ATTACHMENT 1 TO #752

MISSOURI HOSPITAL ASSOCIATION

Marc D. Smith, Ph.D., President

June 24, 2005

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1500–P
P.O. Box 8011
Baltimore, MD 21244–1850

Re: Comment on 42 CFR 412, Hospital Quality Data Component of Proposed Changes To The Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates , File Code CMS-1500-P

To Whom It May Concern:

On behalf of the Missouri Hospital Association's 141 members, thank you for the opportunity to comment on the proposed changes to 42 CFR 412. As indicated above, these comments pertain only to Section 412, Hospital Quality Data Reporting.

MHA and its member hospitals support aspects of the proposed rule that coordinate measurement activities between the Centers for Medicare & Medicaid Services and the Joint Commission focusing on the initial 10 measures that are part of the Hospital Quality Allowance. In addition, we support options allowing hospitals to use the CMS CART tool, ORYX performance measurement systems or other third party vendors that meet defined requirements. These provisions allow hospitals to focus improvement activities in clinical areas important to the hospital, as well as the CMS and the Joint Commission. It also avoids duplication of measurement activities that would require additional resources and cost for hospitals and allows hospitals options to obtain support from measurement systems with expertise in performance measurement to assist in data collection, submission and analysis.

However, the proposed changes include several areas of major concern. These areas are the proposed hospital data reporting provision requiring hospitals to meet an 80 percent threshold for data validation to obtain the full marketbasket and the expectation that electronic medical records be used to submit data directly to the CMS data warehouse. Details of issues relating to the data validation and inaccuracies in the process are more explicitly detailed in the attachment to this letter. To address these concerns, we suggest the following changes to the proposed rule.

- Defer the requirement for hospitals to achieve a defined percentage compliance for data validation until the CMS processes and procedures are clarified and monitored and evidence is provided to hospitals and performance measurement vendors that such processes are complete, timely and accurate.

P.O. Box 60 Jefferson City, MO 65102-0060 Phone: 573/893-3700 Fax: 573/893-2809 *www.mhanet.com*

- Defer the time period for which any validation requirement affecting marketbasket until at least the first quarter 2005 discharges. The CMS and the Joint Commission algorithms for data elements were not fully aligned until January 2005. The current proposed requirement ties reimbursement to achieving 80 percent validation compliance beginning with third quarter 2004 data. The proposed requirement would be based on data that has not been sufficiently analyzed to ensure differences in the CMS and the Joint Commission algorithms that existed in the third quarter 2004 do not affect validation results.

- Financial support and appropriate technical assistance to hospitals should be provided prior to or at least in conjunction with any requirement for hospitals to implement electronic medical records and submit data directly to the CMS data warehouse. Implementation of electronic medical records is currently cost prohibitive for many hospitals and health systems. In addition, current processes and procedures established by CMS are insufficient to provide adequate technical support to hospitals for direct data submission to the data warehouse.

We appreciate your consideration of these comments and recommendations. If you have any questions, please contact me at 573/893-3700, ext. 1329 or *bmiller@mail.mhanet.com*.

Sincerely,

Becky Miller

Becky Miller
Vice President of Quality and Regulatory Advocacy

bm/tl

attachment

Attachment 2 to #752

Hospital Data Quality Rule
42 CFR 412 — File Code CMS-1500-P
Concerns Regarding Data Validation Requirements
June 24, 2005

Accuracy of Validation

The proposed requirement to achieve at least an 80 percent validation begins with third quarter 2004 data before the January 2005 full alignment of the CMS and the Joint Commission algorithms. Before 2005, the CMS and the Joint Commission's abstraction guidelines did not match for all data elements. This caused hospitals to have mismatches counted against them, although the Joint Commission's abstraction guidelines were followed. No statistical evidence or other evidence that alignment issues between the CMS and the Joint Commission algorithms before January 2005 have been adequately addressed in the validation process to account for the differences in algorithms that existed through fourth quarter 2004. Because no evidence has been provided and hospitals historically have had "mismatches" counted against them that should not have been, a hospital's reimbursement should not be affected until clear evidence is provided that the CMS has addressed the issue.

The following are only a few examples of mismatches and existing unresolved problems in the validation process.

- A hospital abstracted a pneumonia working diagnosis as "no"; the CMS data abstractors abstracted it as "yes". In one state, the CMS abstractors counted every data element in the measure as a mismatch, yet in another state only the one data element, working diagnosis of pneumonia, was counted as a mismatch. This one example alone results in a major discrepancy in scoring between hospitals and CMS as well as between states that has not been resolved.

- A hospital coded pneumonia as a principle diagnosis with heart failure as a secondary diagnosis; CMS abstracted it as heart failure being primary and pneumonia as a secondary diagnosis. On the June monthly conference call with CMS and JCAHO this example was discussed with the conclusion that a mismatch on the principle diagnosis would be a mismatch for this one data element. In the above actual example, the mismatches for every data element for the entire measure set were counted against the hospital for validation purposes.

- A patient had a heart failure clinical pathway in the medical record with the education section completed documenting that all of the required heart failure discharge instructions were provided during hospitalization. The CMS data abstractors documented this as missing discharge instructions.

Software algorithm differences still exist between the CMS and the Joint Commission data collection tools that can lead to "mismatches", regardless of the CMS and the Joint Commission indicating they have attempted to address the potential mismatches. There is currently no

evidence that these issues have been addressed adequately and will not result in inaccurate "mismatches" being counted against a hospital. For example,

- A patient had a "hold" order for ACEI documented in the record and there was an order to discontinue lisinoprin prior to discharge. The CMS abstractors have been instructed that documentation such as a hold/discontinue for a medication is sufficient evidence of a contraindication, therefore would abstract this as a "yes", an allowable contraindication to giving the ACEI. The JCAHO abstraction guidelines require an explicit reason for holding a medication to be documented in order for this data element to be counted as a "yes"; the hospital answered "no" because no explicit reason was given for not giving ACEI.. In this case, a mismatch was counted against the hospital that should have been considered an allowable mismatch.

- The CMS abstraction guidelines require abstractors to enter "9999" as an allowable value for a time if there is no time specified for obtaining a blood culture; however, the JCAHO guidelines require a specific time to be entered or for the field to be left blank. This was counted as a mismatch because there was no "9999" which was not possible to enter for the JCAHO abstraction.

- A hospital abstracted antibiotic prior to arrival as "no"; the CMS abstracted it as "yes" because it was documented in nursing documentation for arrival medication. The JCAHO manual and guidelines require documentation of the patient actually taking the medication, such as, "took this morning" to meet the defined criteria for data abstraction.

The validation process currently does not match its intended outcome. If the intention is to validate that the publicly reported performance numbers are accurate, then the validation process should reflect that intention. Currently, the process is simply a data element validation of data abstraction instead of the accuracy of the clinical care provided. For example,

- For a patient to be included in the numerator of the heart failure measures for discharge instructions, the instructions must include six different items. If the CMS abstractor says four out of six items were included and an individual hospital abstractor says five of six items were included, the performance matches for that patient because not all six items were addressed with the patient. However, the CMS will count one mismatch even though the performance would not change based on that one mismatch.

- If a hospital abstractor mistakenly says a patient does not have LVSD, there will be a mismatch counted for that data element, as well as ACE-I Clinical Trial Status, ACE-I Contraindication and ACE-I Prescribed at Discharge. Four data element mismatches will be counted because of one error.

Process Issues

The validation score is to be determined using all data submitted by a hospital to the CMS data warehouse, not just the data required for the 10 indicators as defined in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 which is the basis for the marketbasket

incentive. A hospital could be penalized by not obtaining the full marketbasket based on data that is not required to be submitted by law to obtain full marketbasket.

The validation score is dependent on the processes performed by the CMS on data contained in its warehouse. These processes routinely have been ineffective and/or inaccurate. In addition, communication between the CMS, quality improvement organizations and hospitals and between the CMS, QIOs and performance measurement vendors, which are responsible for submitting accurate data to the warehouse, has been less than ideal. For example, the CMS's QNET Exchange, in coordination with state QIOs, erroneously sent an e-mail message recently to hospitals asking them to review their third quarter 2004 data posted on QNET Exchange. The data posted was inaccurate, leading to mass confusion and panic on the part of hospitals and performance measurement systems because the accuracy of the third quarter data is required to achieve full market basket. Within 24 hours, the CMS reissued an e-mail indicating the data was inaccurate and asked hospitals to view and confirm their data again. In addition, most recently hospitals that had been informed they had successfully passed validation were subsequently informed that had not passed validation as a result of technical errors by CMS in calculating data from the warehouse. These are only two examples of many instances during the past several years of inaccurate CMS processes, timing issues and communication issues that must be corrected before hospital payment is tied to any requirement that is dependent upon the CMS processes and data warehouse.

Up until recently, hospitals were not able to reconstruct the percent of data abstraction agreement using the CMS case detail and summary reports because the methods used to construct the scores were not provided by CMS. Therefore, hospitals did not have enough time or information to adequately review and analyze its own data in the CMS warehouse, which is now proposed to be used for reimbursement purposes.

Hospitals have identified that mismatches contained on the CMS summary report are not always included on the CMS detail report making it even more difficult for hospitals to verify their calculations. When the state's QIO, as technical support for the project, was contacted regarding this concern, they were unable to provide an answer as to why this occurred.

The CMS will not accept documentation from the hospitals after the validation results have been published. Hospitals should be able to submit documentation to the CMS to prove that care took place. This is especially true with the proliferation of data being held electronically and not physically placed in the paper records, which may inadvertently be left out of the copies sent to the CMS. Although hospitals are not allowed to submit additional information to ensure accurate reporting, CMS routinely recalculates data that changes hospital scores after they are published.

Some hospitals have failed validation in some quarters because medical records were not sent to the CMS. However, hospitals maintain that no request for the records was received. Records not submitted by the hospital will affect the validation results, because all data elements will fail validation for every case not received. As a result, the hospital will not obtain its full marketbasket through to no fault of their own.

The CMS only gives hospitals 10 days to respond to validation reports. This is not enough time to respond to the CMS with an appeal, especially considering the complexity of the problems hospitals have encountered with the reports.

The expectation that hospitals eventually will use electronic medical records to submit data directly to the CMS data warehouse is concerning because it may place additional burdens, costs and require additional resources for hospitals to perform this function. Many hospitals do not have resources to obtain electronic medical record programs and currently are using performance measurement systems for this technical support because the hospital does not have the expertise to provide this information

Validation Analysis Issues

The percentage of validation is based on a small sample of five records provided by the hospital to the CMS for re-abstraction. The CMS data abstraction process is an inexact process that is known to have resulted in errors in data abstraction on the CMS part. A sound process to address errors in reabstraction that adversely can affect hospitals, including a process allowing enough time for hospitals to respond to issues and issue appeals, must be in place before any hospital can be penalized for not obtaining full marketbasket because of an error caused by the CMS abstraction stet.

The proposed design study is really a reliability study, not a "validity" study because it compares one abstraction process to another. To treat the results as a measure of validity, the re-abstraction by CMS would need to be systematically error-free and highly, if not perfectly, reliable. To date, no information has been provided confirming the reliability of the CMS abstraction process is. If the CMS inter-rater reliability is not very high (i.e. > .9), an additional component of variability that is attributable to the CMS ratings should be factored into the computation of the confidence interval for the agreement statistic.

Percent agreement (concordance) has well known limitations as a measure of reliability. The percentage is not corrected for chance agreement, which can be very high if the base proportion of a given event being abstracted is either very low or very high. Cohen's Kappa and other measures of intraclass correlation are better suited to correct for this type of upward bias.

The proposed method for computing CI's around the agreement statistic is sound assuming that the re-abstraction is valid and relatively error-free, which, as indicated above, has not been proven. If estimated agreement on the 10 measures of interest and its confidence interval are the criteria to be used to determine if a hospital meets the threshold of acceptability, what is the rationale for performing a full-scale assessment of reliability based on all fields?

457

Submitter : Dr. Barry Arbuckle

Organization : MemorialCare Medical Centers

Category : Hospital

Date: 06/24/2005

Transfer
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QData

Hefter
Hartstein
Walz
Hart
Romano
Bodden
Hammel

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-754-Attach-1.PDF

ATTACHMENT TO # 754

MEMORIALCARE®
Memorial Health Services

June 24, 2005

Mark B. McClellan, M.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P. O. Box 8010
Baltimore, MD 21244-1850

Via: Electronic Mail

Attention: CMS-1500-P

Dear Dr. McClellan:

As President and Chief Executive Officer of MemorialCare Medical Centers (MemorialCare) a five-hospital, not-for-profit health system in Los Angeles and Orange Counties, I welcome the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule entitled "Medicare Inpatient Prospective Payment System (PPS): The Proposed Rule for Fiscal Year 2006".

MemorialCare is an integrated health care system founded on the traditional values of not-for-profit community service. Our projected adjusted patient days for fiscal year 2005 are 497,000 on a base of 112, 000 patient discharges. With over 185,000 visits to our Emergency Departments, including one Level II trauma center, we also served our communities by performing 50,000 surgeries and delivering 13,000 babies.

We feel it critical to our future that you address a number of important issues that will affect hospital financing in the coming year. I will give our view on the Post-Acute Transfer Policy (PAC), then comment on the consequences if there is further proliferation of physician-owned, limited service hospitals. Finally, I'd like to discuss the proposed criteria for the reporting of hospital quality data.

Post-Acute Care Transfer Policy (pages 23411-58)

The proposed rule will expand the post-acute care transfer policy from 30 Diagnosis Related Groups (DRGs) to 223 DRGs in FFY 06. Using the MEDPAR 2006 data file, created by CMS on 6/1/05, and the Revised Table 5-DRG Relative Weights (CMS, 6/1/05), this rule change will cost MemorialCare over $2 Million in federal reimbursement. As a community-based system, the potential loss of these critical dollars presents a new unfunded mandate and is unacceptable in an environment in

which the actual costs of care continue to rise. CMS believes that the proposed change will expand the application of PAC transfer policy to DRGs that have both a relatively high volume and a relatively high proportion of PAC utilization. In reality, this rule will prove to be another barrier to MemorialCare serving its communities.

MemorialCare is committed to ensuring that its Medicare patients receive care in the most appropriate setting, e.g. acute care as long as needed, with transfer to a lower level of care as soon as the individual patient's care warrants same and with the goal of ensuring maximum individual functioning into the future. One of the long-standing principles behind PPS is that some cases will cost more than the DRG payment, while other will cost less. On average, we expect the payments to be adequate over the entire affected population. As proven by the calculations of our losses as noted above, this rule change is clearly detrimental and harmful to community-based hospitals.

MemorialCare is fully committed to quality care based on best practice, evidence based medicine. Expanding the DRG's affected by the PAC transfer policy will compromise clinical decision-making and penalize those providers of care such as MemorialCare for providing efficient care, at the most appropriate time, and in the most appropriate setting.

MemorialCare respectfully requests CMS reverse its support of this proposed rule change, and retain the current 30 DRGs. We believe that the people for whom we provide care and you provide coverage will be best served accordingly.

Limited Service Hospitals (page 23447)

In the proposed rule change, CMS has stated that certain limited service hospitals do not qualify under the Medicare stated definition of a "hospital" – that they be engaged primarily in furnishing services to hospital inpatients. MemorialCare commends CMS for taking this step.

Community based hospitals, guided by EMTALA and other licensing requirements are mandated to serve all patients presenting in the emergency department. Our mission commands us to provide service to our community without regard to a patient's ability to pay. Physician-owned, limited service hospitals operate under no such guidelines. Any physician referring a patient to a hospital in which he/she holds a financial interest clearly has a conflict of interest.

The impact of the limited service hospitals on the communities in which they now exist is not yet fully appreciated and the potential to disrupt the availability of comprehensive medical services in these communities remains an important and unanswered question. It is critical that the expansion of limited service hospitals be curtailed until the impact of these hospitals on access to comprehensive health services in their communities can be accurately assessed.

While MemorialCare is in general support of CMS's position, at the same time, we must respectfully request that all Medicare applications submitted by these physician-owned, limited service hospitals during the recently expired moratorium, be denied. We further request that the six-month freeze imposed on June 8, 2005 by CMS on new applications be held fast.

Reporting of Hospital Quality Data (pages 23424-426)

Pursuant to the proposed rules, CMS will be utilizing Clinical Data Abstraction Contractors (CDAC) to validate quality data submitted to the Clinical Data Warehouse. MemorialCare voluntarily participates in the Hospital Quality Alliance, a public-private collaboration to improve the quality of healthcare by the monitoring and public disclosure of quality outcomes. This collaboration includes the CMS and the American Hospital Association. Further, it is supported by other organizations such as the Agency for Healthcare Research Quality (AHRQ), the National Quality Forum (NHF) and the Joint Commission on Accreditation of Healthcare Organizations JCAHO).

MemorialCare is supportive of any effort to streamline the data collection and submission process, and to decrease the financial burden to hospitals which is associated with participation in this and other quality initiatives.

Thank you for the opportunity to present our views on this very important issue. The final disposition of the proposed rules will have a long lasting affect on MemorialCare and thousands of other not-for-profit hospitals. Our mission is to improve the health and well-being of individuals, families and our communities through innovation and the pursuit of excellence in all that we do. As proof of our commitment to serving our communities, MemorialCare contributed over $63,400,000 in total quantifiable community benefits in FY 2004. Any losses to our reimbursements for the care given to our Medicare patients will have a devastating affect on our ability to take care of those most in need.

MemorialCare will be happy to work with CMS on these and any other issues discussed above, or any other topics that relate to the complexities of hospital financing.

If you have any questions concerning these comments, please feel free to contact me at (562) 933-1833, or Peter J. Mackler, Director of Government Relations and Policy at (562) 933-1836.

Sincerely,

Barry Arbuckle, Ph.D.
President and Chief Executive Officer

458 BODDEN [redacted] HAMMEL HEFTER HARTSTEIN

Submitter : Ms. Glenda Van Roekel **Date:** 06/24/2005

Organization : Avera McKennan Hospital & University Medical Cente

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments regarding Hospital Quality Data from Avera McKennan Hospital & University Medical Center

CMS-1500-P-717-Attach-1.DOC

Q DATA

HOSPITAL QUALITY DATA

Comments on data provisions of FY'06 Medicare Inpatient Prospective Payment System (PPS) Proposed Rule
Avera McKennan Hospital & University Medical Center
Sioux Falls, South Dakota

The ability of hospitals and their vendors to comply with the requirements for timely and accurate data submission has been challenged by miscommunication over data edits, technical ambiguities, and other issues. The final rule governing the FY'06 Inpatient PPS should establish a clear documentation and communications process for this purpose. Hospitals should not be penalized when technical issues specific to the Centers for Medicare and Medicaid Services (CMS) or Quality Improvement Organizations (QIOs) hinder their ability to meet specific data requirements.

Data Submission

- The parameters of the data submission process should be stated explicitly and documented. This includes exact specifications, all edits or audits to be applied, and other related information. Hospitals and their submission agents (vendors) must be privy to such parameters to ensure timely data submission. In addition, CMS should communicate any changes to submission file requirements no less than 120 days prior to the effective/implementation date. No changes should be permitted once a submission quarter has begun, as this puts the integrity of the process at risk.

- For greater reporting accuracy, a test process for validating data file submissions and measuring calculations should be established. Hospitals and submission agents should be provided with a test file in the appropriate file specification format for internal verification *prior* to testing a submission. The process should permit submission of test file(s) to verify file formats, accuracy of data calculations, and other audit criteria related to data submission. An appropriate test process should be permitted each time changes in data submission or measure specifications are prescribed.

- In the proposed rule, there is no mention of a minimum sample size for hospitals that elect to sample. Alternately, if hospitals that do *not* sample elect to submit all of their qualifying cases for a given study (i.e., 425 pneumonia cases for a given quarter) and three get "rejected," will they still meet the data requirements—or, must such hospitals correct the case errors so that *every* one gets into the warehouse? Under our reading of the proposed rule, it appears that they do not—so long as such hospitals have met the minimum number of cases required by the "aligned" JCAHO/CMS sampling requirements, however they are established.

Data Validation

- The parameters of the validation process should be stated explicitly and documented. This includes clear definitions, all applicable skip logic, all edits or audits to be applied, and other related information. Hospitals must know exactly *what* is being validated so they may adhere to the specifications during the data collection process. Under the current process, by the time hospitals receive feedback on one quarter's validation, they have already moved onto the next quarter's data collection and cannot make changes quickly enough to impact the next quarter. If the validation specs and requirements were clear and well-documented, hospitals could be proactive. Any changes must be communicated clearly and within a timeframe sufficient for hospitals to react and changes their attendant processes. Any modifications to the technical processes should be published 120 days prior to the effective/implementation date.

- The validation process should incorporate *only* data associated with the ten specified measures. Under the current system, a hospital that submits multiple data sets may earn an *overall* quality score of 80 percent; however, if errors occur more frequently in the subset required for the annual payment update, the quality of such data may be considerably *lower*. In this way, payments risk being based on inconsistent calculations and inaccurate data.

- Hospitals should be notified of any validation rule changes at least 120 days prior to the hospital data abstraction period. The validation rules applied by CMS as of June 6, 2005 are, in fact, retroactive to the July—September 2004 data. CMS validated the three test LDL measures for the AMI clinical focus group. Consequently, hospitals are receiving mismatches for not collecting this optional data. The validation documentation for the July 1, 2004 discharges is dated April 29, 2005. Since the data was submitted at the end of January, hospitals have not had sufficient time to make the appropriate change.

- Under the proposed rule, CMS only allows ten days for a hospital to appeal its validation; however, the agency fails to specify whether the reference is to "business" or "calendar" days. N*either* case offers sufficient time for hospitals to respond. Therefore, we propose allowing hospitals 30 calendar days to appeal their validation findings.

- Many hospitals report having received inconsistent communications relating to the "data reporting for annual updates" provision of the Medicare drug law (MMA). All communications and directives regarding this initiative should be centralized and disseminated to all stakeholders (hospitals, vendors, and QIOs) simultaneously. Such a strategy would simplify and standardize message generation. It would also eliminate the confusing and often contradictory communications typical of the current process, which requires state QIOs to interpret a given communication before forwarding it to hospitals.

Attachment to #717

- The validation process is directed at medical record documentation and abstraction, not whether appropriate care is provided. Example, comparison of blood culture collection time documented by the R.N. with the time printed on laboratory report to verify data abstraction. The important point is the blood culture was drawn prior to the first antibiotic. Premier believes that ensuring patients receive the right care at the right time should be incorporated into the validation process.

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RUIZ
HEFTER
HARTSTEIN

Submitter : Mr. Santiago Munoz **Date:** 06/24/2005

Organization : University of California

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-715-Attach-1.PDF

MB/H
Q DATA
LABOR S/H
TRANSFER
PYMT RTS/OUT
WI/~~OM~~
WI/BD
GME/IRP
W/GEN IMPACT

Same as CMS-1500-P-729

ATTACHMENT TO # 715

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June 23, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Ave, SW
Washington, DC 20201

SUBJECT: **CMS-1500-P** – Proposed Medicare Inpatient Prospective Payment System Rates for Fiscal Year 2006

Dear Administrator McClellan:

Thank you for the opportunity to comment on the Medicare Inpatient Prospective Payment System (PPS) proposed rule for Fiscal Year (FY) 2006 issued by the Centers for Medicare & Medicaid Services (CMS) on May 4, 2005. These comments are provided on behalf of the University of California (UC), Office of the President, Clinical Services Development Division, and UC's five academic medical centers (AMCs) located in Davis, Los Angeles, Irvine, San Diego, and San Francisco.

Together, the UC AMCs are the fifth largest healthcare delivery system in California, the leading provider of certain specialty services and medical procedures, and one of the state's largest providers of care to Medicare patients. Annually, the academic medical centers provide patient care services valued at over $3.3 billion. In alignment with its patient care work, the AMCs also play a critical role in a number of broad public-policy goals, including the education of health professionals and the advancement of medical science through cutting-edge research. Specifically, UC medical centers offer services that are essential to the health and well b eing of Medicare beneficiaries including a broad-array of highly specialized services, such as cancer centers, geriatric and orthopedic centers of excellence, organ transplant programs, and world class primary and preventive care.

The University is extremely concerned with the decline of its aggregate Medicare payments given its important role in providing medical education, which Medicare funds, and in serving extremely high-cost Medicare beneficiaries. UC continues to urge Congress to provide adequate Medicare payments to its hospitals and urges CMS to ensure the Congressional intent of hospital payment updates is fully implemented on a programmatic level. Further, while UC's comments address the most significant areas of concern for its AMCs, it urges CMS to make changes to the proposed rule that would prevent further decline in Medicare payments to its medical centers.

- Hospital Market Basket

For the last few years, the market basket projection has been lower than the actual increase. CMS reports that, based on the most recent data, the FY 2005 market basket increase is now estimated to be 4.1 percent compared to the projected 3.3 percent increase that was used to determine the update factor. Given a 4.1 percent actual cost increase for FY 2005, a projected FY 2006 increase of 3.2 percent does not square with the continued increase in the price of goods and services hospitals purchase to furnish inpatient care. **Consequently, UC respectfully requests that CMS 1) further review the methodology that was used to determine the projected FY 2005 market basket, 2) provide hospitals with the opportunity to review and comment, and, if appropriate, 3) revise the FY 2006 projection.**

- Hospital Quality Data for Full Market Basket Update

For 2006, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) updated the inpatient PPS rates equal to the full market basket (currently forecasted at 3.2 percent) for those hospitals that submit data on 10 clinical measures of quality care. Those hospitals that do not submit quality data would receive a payment rate update of market basket minus .4 percent (currently forecasted at 2.8 percent).

The UC AMCs are concerned that the proposed rule enacts a burdensome and unproven validation requirement for those hospitals submitting quality data. While the University strongly supports validating data submitted by hospitals, it is concerned that the existing validation process is unreliable and needs improvement. **Consequently, the UC AMCs oppose the currently proposed validation requirement for payment purposes. In its current form, the requirement may circumvent the Congressional intent of ensuring a full market basket adjustment for hospitals submitting the quality data.**

- Labor-Related Share of the Hospital Market Basket

Under the current rules, the labor-related share is used to determine the proportion of the national PPS base payment rate to which the area wage index (AWI) is applied. CMS is proposing to reduce the labor-related share from 71.1 percent to 69.7, to reflect more recent data. This proposed rule change, if adopted, would adversely affect hospitals with an AWI of greater than 1.0. The proposed rule would apply this change in a budget neutral manner. While we understand the Congressional intent of budget neutral

changes, it is extremely difficult to square reductions in labor-related updates for the UC AMCs with the financial impact of operating in some of the most expensive and onerous labor markets in the entire country. Further, our hospitals are reeling from the impact of increased staffing costs related to the state statutorily mandated nurse-staffing ratios expenses. These expenses, along with enormous inflationary pressures for other scarce clinical staff, are not reflected in historical cost data. **Consequently, UC urges CMS to ensure that labor-related changes do not adversely impact hospitals, such as the UC AMCs, and ensure that the most reliable data is utilized in constructing the payment update.**

- Expansion of the post-acute care transfer policy to additional diagnosis-related groups (DRGs)

Since FY 1999, selected Medicare patients discharged to a post-acute care setting – including rehabilitation hospitals and units, long-term care hospitals, or skilled nursing facilities – or discharged within three days to home health services have been defined as transfer cases when their acute care length of stay is at least one day less than the national average. These cases are paid a per diem rate, rather than a fixed DRG amount, up to the full PPS rate. Thus, if a patient has a shorter than average inpatient stay, even by just one day, the hospital is paid less than the full DRG rate.

CMS is proposing to expand the post-acute care transfer policy to a total of 223 DRGs. This change would financially penalize hospitals, such as the UC AMCs, which have worked aggressively to reduce length-of-stays and ensure patients are placed in the most appropriate clinical setting. Also, the UC AMCs have adopted new costly technologies, such as robotic surgery, that have reduced length of stays and improved patient care. The new policy would penalize hospitals that have invested heavily in these new technologies. Further, because of capacity issues and the need to ensure timely access to care for Medicare beneficiaries, the UC AMCs have worked hard to improve patient through put. Unfortunately, the post-acute transfer policy penalizes hospitals for efficient treatment and for ensuring that patients receive the right care at the right time in the right place. **UC's preliminary assessment indicates the financial impact of this policy could be between $15 million and $20 million annually.**

Further, the expansion of the transfer policy undermines the principles and objectives of the Medicare prospective payment system. Under PPS, cases with higher than average lengths of stay tend to be paid less than costs while cases with shorter than average stays tend to be paid more than costs. The expansion of this policy makes it impossible for hospitals to break even on patients that receive post-acute care after discharge. Hospitals are both financially penalized if a patient is discharged prior to the mean length of stay if the patient is discharged after the mean length of stay.

The DRGs selected for the post-acute transfer policy expansion represent the vast majority of discharges to post-acute care. As such, UC is concerned with the criteria used to select these DRGs as disproportionate utilizers of post-discharge services. The proposed policy change is premised on an apparent "disproportionate" use of post-

discharge services, but as the universe of DRGs subject to this policy grows to include the majority of DRGs with post-discharge services, it is unclear how a disproportionate amount is measured. UC is concerned that the current criteria captures far more DRGs than appropriate.

The UC AMCs object to the expansion of the post-acute care transfer policy and respectfully request this proposal be withdrawn from the final rule. This proposal undermines the basic principles and objectives of the Medicare PPS and clinical decision-making. Further, this proposal penalizes hospitals for providing efficient care at the most appropriate time and in the most appropriate setting.

- Outlier Payments

The proposed rule establishes a fixed-loss cost outlier threshold at the inpatient PPS rate for the DRG, including IME, DSH, and new technology payments, plus $26,675. While this is not a particularly sizable increase from the FY 2005 payment threshold of $25,800, UC is concerned that the overall threshold is too high and will result in an overall outlier payment amount less than 5.1% budget neutrality target. CMS has indicated that FFY 2004 outlier payments will represent only 3.5% of total DRG payments and FFY 2004 payments will represent only 4.4% of total DRG payments.

The University supports the analysis conducted by the American Hospital Association and Federation of American Hospitals that indicates the fixed-loss threshold should be reduced to $24,050. Further, UC respectfully urges CMS to implement no change that would inappropriately increase the cost outlier threshold and effectively result in payment reductions to hospitals.

- Occupation Mix Adjustment

The occupational mix adjustment to the wage index is intended to control for the effect of hospital employment choices – such as the use of registered nurses versus licensed practical nurses or the employment of physicians – rather than geographic differences in the costs of labor. Although there is no proposal to change the methodology used in FY 2005 in the proposed rule, CMS indicates that over half of urban areas would see a decrease in their wage index as a result of this adjustment. This policy continues to be of significant concern to UC AMCs, which operate in extremely expensive and tight labor markets and whose employee mix is driving by the high-end specialty, tertiary, and quaternary care provided to patients. **Consequently, UC AMCs respectfully request that CMS implement changes to ensure the occupational mix adjustment does not adversely impact hospitals such as the UC AMCs.**

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The proposed rule contains a change in the wage index calculation, which specifically relates to the Overhead Wage-Related Cost Allocation to Excluded Areas. The new computation results in an increase in the overhead cost allocated to exclude areas and

lowers a hospital's average hourly rate. UC is concerned that this will have an impact on the wage indexes for some of its hospitals. **As such, UC requests that CMS go through the full notice and comment process before making such a change.**

The University is also very concerned with the proposed changes to the computation of pension and other deferred compensation costs for constructing the wage index. The proposed rule indicates that, beginning in 2007, hospitals must comply with PRM, Part I, sections 2140, 2141, and 2142 and related Medicare program instructions for developing pension and other deferred compensation plan costs as wage-related costs for the wage-index. CMS has offered no rationale for moving away from the reliance on GAAP. This change would result in understated costs at government owned hospitals, such as the UC AMCs, that account for pension related expenses pursuant to government accounting standards. **As such, the UC AMCs request that CMS consider the unique circumstances of publicly operated hospitals and retract this change. At a minimum, CMS should offer a rationale for the proposed change and provide a full notice and comment process.**

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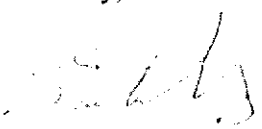
For 2005, CMS instituted a new policy for weighting the direct GME resident count for residents that pursue specialties requiring an initial year of broad-based training, such as anesthesiology. The new policy allows the initial residency period to be based on the period of board eligibility for the specialty, rather than the clinical-base year. Now, CMS further proposes basing initial residency period on the period of board eligibility for the specialty when a resident matches directly to an "advanced program" without regard to fact that the resident did not match for an initial clinical base-year training program. This change would allow hospitals to be paid an entire full-time equivalent (FTE), rather than half of an FTE for such residents until they are board eligible. **The UC AMCs support this change.**

Thank you for the opportunity to comment on the Medicare Inpatient PPS proposed rule for FY 2006. If there are questions or if I can provide any additional information or input, please contact me at 510-987-9062 or santiago.munoz@ucop.edu.

Sincerely,



Santiago Muñoz, Executive Director
Clinical Services Development

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Submitter : Mr. Santiago Munoz
Organization : University of California
Category : Hospital
Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-729-Attach-1.DOC

MB/H
Q DATA
LABOR S/N
TRANSFERS
PYMT RTS/OUTLIER
WI/OM
WI/Bd
GME/IRP
WI/GEN
IMPACT

Same as CMS-1500-P 715

Attachment to #729

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June 23, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
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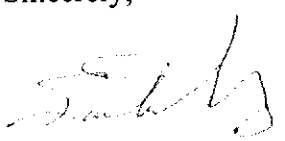

Santiago Muñoz, Executive Director
Clinical Services Development